

<b>Case Number:</b>	CM14-0218933		
<b>Date Assigned:</b>	01/09/2015	<b>Date of Injury:</b>	04/24/2014
<b>Decision Date:</b>	03/27/2015	<b>UR Denial Date:</b>	12/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/30/2014

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 50-year-old female who reported an injury on 04/24/2014 due to a twisting injury. On 06/18/2014, she presented for a follow-up evaluation regarding her work related injury. She reported lumbar spine pain that was slight to intermittently moderate and occasionally severe and radiated into the right lower extremity. She rated her pain in the low back at a 5/10. She also reported right knee and ankle pain rated at a 4/10. A physical examination of the lumbar spine showed 2+ tenderness to palpation over the right paraspinal muscles of the lumbar spine. Special orthopedic testing was negative bilaterally. Range of motion was noted to be normal, but with pain. There was tenderness to palpation over the infrapatellar region of the right knee and she was stable to valgus and varus and anterior/posterior stress. Special testing for the knee was negative and range of motion was noted to be normal. The right ankle showed 2+ tenderness to palpation of the right medial ankle and right lateral ankle and calcaneus muscle. Special orthopedic testing was negative and range of motion was normal. There were no deficits on her neurologic examination. She was diagnosed with lumbar spine sprain and strain, right knee sprain and strain and right ankle sprain and strain. Her prescribed medications included ibuprofen 800 mg, tramadol ER 150 mg, omeprazole 20 mg, orphenadrine ER 100 mg and topical compound creams. The treatment plan was for TG Hot 180 gm/240 gm. The rationale for treatment was to alleviate the injured worker's symptoms.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**TG HOT 180GM/ 240GM:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-114.

**Decision rationale:** The California MTUS Guidelines indicate that topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The documentation provided does not indicate that the injured worker had failed recommended oral medications to support the request for a topical analgesic. Also, the frequency and quantity of the medication were not stated within the request and there is a lack of documentation indicating efficacy with a quantitative decrease in pain and an objective improvement in function. Therefore, the request is not supported. As such, the request is not medically necessary.