

<b>Case Number:</b>	CM13-0002098		
<b>Date Assigned:</b>	12/18/2013	<b>Date of Injury:</b>	02/20/2001
<b>Decision Date:</b>	02/27/2014	<b>UR Denial Date:</b>	07/11/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/19/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Pain Management, has a subspecialty in Disability Evaluation and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

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

According to the medical records, the patient is a 56 years old woman who sustained an industrial injury on February 21/2001. On the visit of June 13, 2013, it was indicated that the patient complained of low back and left leg pain. She stated that the nerve pain that goes down the left leg was not getting better and was actually getting worse. She stated that injections have not helped her. She indicated that sometimes she feels as if she has a knife in her left leg. Objective findings include significant weakness in the left foot, decreased sensation at the level of the LS distribution on the left leg, positive straight LA9 raising at about 30 degrees 1~ith generation of left leg pain, and absent Waddell's sign. Patient stated the medications were giving her adequate response therefore refills were issued in the form of Dendracin lotion as a topical analgesic, Neurontin 600 mg for neuropathic pain, Protonix, Theramine, and GABA done tor nighttime pain.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Dendracin Lotion:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 112.

**Decision rationale:** It is not evident from the review of clinical records from June 13, 2013 that a topical analgesic (Dendracin) is medically necessary for this patient. According to the guidelines, topical analgesics are considered largely experimental in use with few randomized controlled trials to determine efficacy or safety. There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. In this case, Dendracin consists of Methyl Salicylate, Benzocaine, and menthol lotion. Topical lidocaine is only FDA approved in the formulation of a dermal patch (Lidoderm). Additionally, there are no evidence-based guidelines to support the use of menthol as a topical lotion. Review of the clinical records from the June 13, 2013, does not demonstrate that the patient is intolerant to more standard medical treatment, namely oral medications. The patient indicated prescribed medications which included Neurontin were providing relief of pain. The use of Dendracin lotion is not medically indicated or supported by the guidelines. According to CA-MTUS (Effective July 18, 2009) states that Topical analgesics are recommended as an option as indicated below. Largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. (Namaka, 2004) These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. (Colombo, 2006) Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists,  $\alpha$ -adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists,  $\beta$  agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor). (Argoff, 2006) There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. [Note: Topical analgesics work locally underneath the skin where they are applied. These do not include transdermal analgesics that are systemic agents entering the body through a transdermal means. See Duragesic® (fentanyl transdermal system).