

Case Number:	CM13-0033571		
Date Assigned:	12/11/2013	Date of Injury:	04/26/2012
Decision Date:	02/04/2014	UR Denial Date:	10/01/2013
Priority:	Standard	Application Received:	10/10/2013

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 Physical Medicine & Rehabilitation, has a subspecialty in Sports Medicine and is licensed to practice in New York and Texas. 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:

The patient is a 51-year-old female who reported an injury on 04/26/2012 due to a fall, causing injury to her right knee and right hand. The patient underwent an EMG/NCV of the upper extremities that did not reveal any evidence of carpal tunnel syndrome. The patient underwent an MRI of the right knee, revealing a low grade chondromalacia patella but no evidence of a meniscal tear. The patient underwent a right wrist MRI that revealed a nondisplaced linear incomplete tear of the dorsoulnar triangular fibrocartilage. The patient was treated conservatively with medications and physical therapy that failed to resolve the patient's symptoms. The patient's medications included amitriptyline 25 mg, Voltaren XR 100 mg, nabumetone 500 mg and Salonpas large patch. The patient's most recent clinical examination findings included pain relief rated at a 5/10 with medications. Objective findings included painful movements of the right wrist and tenderness to palpation over the TFCC with a positive Froment's sign and Wartenberg's signs on the right hand. The clinical findings of the right knee included tenderness to palpation over the lateral joint and medial joint lines with no significant effusion and a negative McMurray's test. The patient's diagnoses included pain in joint of the lower leg; pain in joint of the upper arm; elbow, forearm and wrist injury and ulnar nerve lesion; right CMC joint arthritis and right patellofemoral syndrome. The patient's treatment plan included the continued use of medications and carpal tunnel release of the right hand.

IMR ISSUES, DECISIONS AND RATIONALES

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

Dendracin Lotion .025 30-10%, apply to skin as needed: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.drugs.com/cdi/dendracin-lotion.html>.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111,60.

Decision rationale: The requested Dendracin lotion 0.025 30-10% apply to skin as needed is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has been using this medication for an extended period of time. However, the clinical documentation submitted for review does not provide any evidence of significant functional benefit or pain relief as a result of this medication. The requested Dendracin cream contains methyl salicylate, menthol and capsaicin. The California Medical Treatment Utilization Schedule does recommend the use of methyl salicylate and menthol for relieving symptoms related to osteoarthritic conditions. However, the California Medical Treatment Utilization Schedule does not recommend the use of capsaicin as a topical agent unless the patient has failed to respond to other treatments. The clinical documentation submitted for review does not provide evidence that the patient has failed to respond to first-line and other types of oral analgesics. Additionally, as the patient has been on this medication for an extended period, there should be documentation of functional benefit as it is related to this medication. As there is no documentation of pain relief or functional benefit and the use of capsaicin is not recommended by the California Medical Treatment Utilization Schedule, continued use would not be indicated. As such, the requested Dendracin lotion 0.025 30-10% apply to skin as needed is not medically necessary or appropriate. .

Voltaren XR 100 MG Tablet once daily: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 60,67.

Decision rationale: The requested Motrin XR 100 mg 1 tablet daily is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has been on this medication for an extended period of time. The California Medical Treatment Utilization Schedule recommends that the continued use of medications in the management of a patient's chronic pain be supported by symptom relief and functional benefit. The clinical documentation submitted for review does not provide any evidence that the patient has any functional benefit related to this medication. Additionally, there is no documentation of significant pain relief as a result of this medication. As such, the requested Voltaren XR 100 mg tablet once daily is not medically necessary or appropriate.

Docusate: 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 Opioids Initiating Therapy Page(s): 77.

Decision rationale: The requested docusate is not medically necessary or appropriate. The clinical documentation submitted for review does not provide any evidence that the patient is on any opioid therapy. The California Medical Treatment Utilization Schedule recommends prophylactic treatment of constipation when initiating opioid therapy. The clinical documentation submitted for review does not provide any evidence that the patient has been recently prescribed opioids to manage the patient's chronic pain. Additionally, there was no documentation that the patient was experiencing constipation as a result of medication usage that would support the need for this medication. As such, the requested docusate is not medically necessary or appropriate. .