

Case Number:	CM13-0054674		
Date Assigned:	12/30/2013	Date of Injury:	10/21/2008
Decision Date:	03/24/2014	UR Denial Date:	10/30/2013
Priority:	Standard	Application Received:	11/19/2013

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 Internal Medicine has a subspecialty in Pulmonary Diseases 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:

The patient is a 58-year-old female who reported an injury on 10/21/2008. She has a history of right carpal tunnel release, left epicondylectomy, and bilateral hand arthralgia. The note dated 05/804/2012 from Hand Therapy and Occupation indicated an evaluation and treatment plan for 2 times a week for 6 weeks but did not indicate if she completed any sessions or any outcomes from such session. She was seen on 05/28/2013 for complaints of bilateral hand pain rated at 6-9/10. Her medication regimen included Tramadol 150mg, Elavil 10mg, Voltaren 100mg, and Terocin cream. The patient stated the medications help reduce symptoms. The exam noted 4/5 strength to her bilateral upper extremities, intact sensation, negative Hoffman's, and negative Tinel's. She was recommended to continue her medication regimen.

IMR ISSUES, DECISIONS AND RATIONALES

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

The retrospective request for Dendracin: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112, 105.

Decision rationale: Chronic Pain Medical Treatment Guidelines states topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. It also states, topical Lidocaine use is recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as Gabapentin or Lyrica). Salicylate topicals are recommended; however, the only FDA approved formulation of Lidocaine is Lidoderm. The documentation submitted did not provide any evidence of functional limitations or failed outcomes from other conservative treatments to warrant the need for additional medications. Additionally, the patient stated her current medication regimen provides relief of symptoms. Also, the requested compound includes a non-FDA approved formulation of Lidocaine. Therefore, as the compound product contains at least one drug (or drug class) that is not recommended is not recommended. Given the above, the request is non-certified