

Case Number:	CM13-0060698		
Date Assigned:	12/30/2013	Date of Injury:	05/07/2001
Decision Date:	04/11/2014	UR Denial Date:	11/27/2013
Priority:	Standard	Application Received:	12/03/2013

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, and is licensed to practice in Illinois. 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/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 57-year-old female who reported an injury on 05/07/2001. The mechanism of injury was not provided for review. The patient's most recent clinical documentation dated 10/31/2013 noted that the patient was able to exercise the left arm, shoulder and wrist with water resistance to reduce pain and increase strength. It was noted that a request for authorization for a left wrist support was made. A prescription for Vicodin 1 by mouth every 12 hours as needed for chronic pain, Robaxin 750 mg 1 to 2 by mouth 3 times a day as needed for spasming, and Dendracin topical lotion to treat the patient's tendonitis as the patient was intolerant of oral non-steroidal anti-inflammatory drugs was written.

IMR ISSUES, DECISIONS AND RATIONALES

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

VICODIN 5/500 #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Initiating Therapy Page(s): 77.

Decision rationale: The requested Vicodin 5/500 mg #60 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not recommend opioids as

a first line medication for the management of chronic pain. The clinical documentation failed to provide a treatment history or medication history to support the need for opioid therapy. Additionally, the clinical documentation fails to provide an adequate assessment of the patient's pain that would require pharmacological intervention. Therefore, the need for opioid therapy is not clearly established within the submitted documentation. As such, the requested Vicodin 5/500 mg #60 is not medically necessary or appropriate.

ROBAXIN 750MG #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

Decision rationale: The requested Robaxin 750 mg #120 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends muscle relaxers in the treatment of moderate to severe pain and muscle spasming. The clinical documentation submitted for review does not provide physical evaluation to support that the patient has persistent moderate to severe pain or muscle spasming that would respond to pharmacological intervention. Therefore, the need for a muscle relaxant is not clearly established within the submitted documentation. As such, the requested Robaxin 750 mg #120 is not medically necessary or appropriate.

DENDRACIN TOPICAL LOTION 120ML (BRAND NAME ONLY): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

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

Decision rationale: The requested Dendracin topical lotion 100 mL (brand name only) is not medically necessary or appropriate. The requested medication is a topical compounded cream that contains methyl salicylate, capsaicin, and menthol. California Medical Treatment Utilization Schedule recommends the use of methyl salicylate and menthol for patients with osteoarthritic related pain. The clinical documentation submitted for review does not provide an adequate physical examination or assessment of the patient's pain to support the need for this medication. Additionally, California Medical Treatment Utilization Schedule recommends capsaicin as a topical analgesic after patients have failed to respond to first line treatment. The clinical documentation does not provide a medication history to support that the patient has failed to respond to first line treatments to include antidepressants and anticonvulsants. Therefore, the appropriateness of this medication cannot be determined. As such, the requested Dendracin topical lotion 120 mL (brand name only) is not medically necessary or appropriate.