

Case Number:	CM14-0130785		
Date Assigned:	09/10/2014	Date of Injury:	08/06/2008
Decision Date:	10/20/2014	UR Denial Date:	07/16/2014
Priority:	Standard	Application Received:	08/15/2014

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. The expert reviewer is licensed in Chiropractic, has a subspecialty in Pediatric Chiropractic 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 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 injured worker is a 33 year old female injured on 08/06/08 due to an undisclosed mechanism of injury. Neither the specific injuries sustained nor the initial treatments rendered were discussed in the documentation provided. Diagnoses include degeneration of lumbosacral intervertebral disc and displacement of lumbar intervertebral disc without myelopathy. The clinical note dated 07/07/14 indicated the injured worker presented complaining of bilateral low back pain radiating to the right lower extremity rated at 6/10 with associated weakness, numbness, tingling, stiffness in the low back, and interference with sleep. The injured worker reported an increase in pain level due to non-authorization of medications. The documentation also indicated the injured worker did not graduate from a functional restoration program due to a lack of functional gains. The injured worker reported was previously prescribed topical medications which reduced pain by approximately 40% and allowed sleep. Tizanidine was utilized for muscle spasm and helpful for sleep and activities of daily living. The injured worker reported cessation of work due to increased pain and had no plans to return. Physical examination revealed lightly depressed appearance and diminished sensation in the right lower extremity. Medications included Dendracin lotion, Tizanidine, and Voltaren gel. The initial request was non-certified on 07/16/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Dendracin 0.025%30%10% lotion 12ml bottle QTY: 1 with 2 refills: Upheld

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

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

Decision rationale: As noted on page 111 of the MTUS Chronic Pain Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no indication in the documentation that these types of medications have been trialed and/or failed. Dendracin is noted to contain capsaicin, menthol, and methyl salicylate. There is no indication in the documentation that the injured worker cannot utilize the readily available over-the-counter version of this medication without benefit. As such, the request for Dendracin 0.025%30%10% lotion 12ml bottle #1 with 2 refills cannot be recommended as medically necessary.

Voltaren 1% topical gel 100gm tube, QTY: 1 with 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Voltaren Gel (diclofenac) Page(s): 112.

Decision rationale: As noted on page 112 of the MTUS Chronic Pain Guidelines, Voltaren Gel (Diclofenac) is not recommended as a first-line treatment. Diclofenac is recommended for osteoarthritis after failure of an oral NSAID, contraindications to oral NSAIDs, or for patients who cannot swallow solid oral dosage forms, and after considering the increased risk profile with Diclofenac, including topical formulations. With the lack of data to support superiority of Diclofenac over other NSAIDs and the possible increased hepatic and cardiovascular risk associated with its use, alternative analgesics and/or non-pharmacological therapy should be considered. As such the request for Voltaren 1% topical gel 100gm tube #1 with 2 refills cannot be recommended as medically necessary at this time.

Tizanidine 4mg, QTY: 30 with 2 refills: Upheld

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

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

Decision rationale: As noted on page 63 of the MTUS Chronic Pain Guidelines, muscle relaxants are recommended as a second-line option for short-term (less than two weeks) treatment of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Studies have shown that the efficacy appears to diminish over time,

and prolonged use of some medications in this class may lead to dependence. The request for 2 refills will exceed the 2-4 week window for acute management also indicating a lack of efficacy if being utilized for chronic flare-ups. Additionally, the objective findings failed to establish the presence of spasm warranting the use of muscle relaxants. As such, the medical necessity of Tizanidine 4mg #30 with 2 refills cannot be established at this time.