

<b>Case Number:</b>	CM14-0021878		
<b>Date Assigned:</b>	05/09/2014	<b>Date of Injury:</b>	08/29/2008
<b>Decision Date:</b>	10/14/2014	<b>UR Denial Date:</b>	01/22/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/21/2014

### 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 Board Certified in Internal Medicine 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 37 year old male injured on 08/29/08 as a result of lifting and carrying a wooden pallet over his head across the job site. The injured worker described a sudden onset of back pain. Current diagnoses include chronic pain syndrome, sacroiliac sprain/strain, lumbar facet syndrome, lumbar spondylosis, and myofascial pain syndrome. The clinical note dated 12/12/13 indicates the injured worker presented complaining of persistent pain in the mid back following a functional restoration program. The injured worker reports mid back pain occasionally travels into the upper limbs with occasional weakness described as stabbing pain worse in the evening hours. Physical assessment revealed reproducible left sided pectoralis major tenderness, manual muscle testing 5/5 in all muscle groups, deep tendon reflexes normal in bilateral extremities. The documentation also indicates the injured worker complained of inguinal pain, muscle spasms, and constipation. A request for Dendracin lotion and Butrans patch was submitted. The documentation indicates the injured worker has received benefit from Butrans in the past. Additionally, six chiropractic treatment sessions and surgical evaluation were requested. Prior treatment received includes massage, acupuncture, chiropractic therapy, physical therapy, prescription medications, durable medical equipment (DME) items, and functional restoration program participation. The initial request for 1 prescription of Butrans patch 10mcg/hour #4 with 2 refills was initially non-certified on 01/22/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Butrans Patch 10mcg/Hr #4 with 2 Refills: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Buprenorphine Page(s): 26-27.

**Decision rationale:** As noted on page 26 of the Chronic Pain Medical Treatment Guidelines, Butrans is recommended for treatment of opiate addiction and also as an option for chronic pain, especially after detoxification in patients who have a history of opiate addiction. Suggested patient populations include those with a hyperalgesic component to pain; centrally mediated pain; neuropathic pain; high-risk of non-adherence with standard opioid maintenance; and for analgesia in patients who have previously been detoxified from other high-dose opioids. There is no indication in the documentation that first-line treatment options were attempted prior to Butrans. Additionally, there is no evidence of opiate addiction or prior detoxification requiring specialized medication regimens. As such, the request for one prescription of Butrans patch 10mcg/hr #4 with two refills is not medically necessary.

**Dendracin Lotion 0.025-30-10% with 2 Refills:** Upheld

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

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

**Decision rationale:** As noted on page 111 of the Chronic Pain Medical Treatment 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. This compound is noted to contain capsaicin, menthol, and methyl Salicylate. There is no indication in the documentation that the patient cannot utilize the readily available over-the-counter version of this medication without benefit. As such, the request for Dendracin lotion 0.025-30-10% with 2 refills is not medically necessary.