

Case Number:	CM14-0025570		
Date Assigned:	06/13/2014	Date of Injury:	07/20/2009
Decision Date:	07/18/2014	UR Denial Date:	02/19/2014
Priority:	Standard	Application Received:	02/28/2014

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 Occupational Health and is licensed to practice in 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 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 25 year old male injured on 07/20/09 due to undisclosed mechanism of injury. Current diagnoses included hand and wrist pain. Prior procedures included right wrist carpal tunnel release with flexor tenosynovectomy and soft tissue mass excision on 11/20/09. Clinical note dated 02/06/14 indicated the injured worker presented complaining of right upper extremity pain that decreased since the previous visit. The injured worker reported current medication regimen was working well with no side effects reported. Physical examination of the right wrist revealed limited range of motion, positive Tinel, tenderness to palpation over radial side, ulnar side, anatomical snuff box, and first dorsal compartment, hypersensitivity over volar aspect of right wrist and over thenar eminence. Medications included Norco which reduced pain from 8/10 to 1/10 and increased functionality and ability to perform activities of daily living including grocery shopping and yard work. A request for Dendracin lotion was submitted which the injured worker stated was more effective than Voltaren gel. Prior prescription for Dendracin lotion was reported to have been denied so the injured worker had yet to utilize current prescription. Initial request for Dendracin lotion 10% was initially non-certified on 02/18/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

DENDRACIN LOTION 0375-30 10%: Upheld

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

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

Decision rationale: 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. Guidelines also require that all components of a compounded topical medication be approved for transdermal use. Therefore Dendracin lotion 375-30 10% cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.