

Case Number:	CM14-0084512		
Date Assigned:	07/21/2014	Date of Injury:	01/29/2004
Decision Date:	10/14/2014	UR Denial Date:	05/09/2014
Priority:	Standard	Application Received:	06/06/2014

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 Physical Medicine and Rehabilitation and is licensed to practice in Nevada. 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 records, presented for review, indicate that this 66-year-old female was reportedly injured on January 29, 2004. The stated mechanism of injury was having a patient grab her neck. The most recent progress note, dated July 24, 2014, indicated that there were ongoing complaints of neck pain radiating to the upper extremities and low back pain, which radiated down the left greater than the right lower extremity. Current medications include bupropion, Naprosyn, and hydrocodone/APAP. The physical examination demonstrated spasms and guarding of the right trapezius. There was decreased cervical spine range of motion. An upper extremity neurological examination indicated decreased sensation along all dermatomes of the left upper extremity. There was a positive left-sided Spurling's test. Diagnostic imaging studies of the lumbar spine revealed a spondylolisthesis at L3-L4 with a broad-based disc bulge and disc degeneration at L4-L5 with bilateral nerve compression. There was also a disc bulge at L5-S1 with bilateral compression. Previous treatment included physical therapy, aquatic therapy, acupuncture, and epidural steroid injections. There was also a history of a cervical spine fusion at C5-C6. A request had been made for hydrocodone/APAP and dendracin lotion and was not certified in the pre-authorization process on May 9 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone/APAP 10/325 mg 90, 180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 75 - 80,91, 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26; MTUS (Effective July 18, 2009) Page(s): 74-78, 88, 91 of 127..

Decision rationale: Hydrocodone/acetaminophen is a short acting opiate indicated for the management in controlling moderate to severe pain. This medication is often used for intermittent or breakthrough pain. The California MTUS guidelines support short-acting opiates at the lowest possible dose and that establishes improvement (decrease) in the pain complaints and increased functionality, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The injured employee has chronic pain after a work-related injury; however, there is no objective clinical documentation of improvement in the pain or function with the current regimen. As such, this request for hydrocodone/APAP is not considered medically necessary.

Dendracin Neurodendracin Lotion 030375 percent-10-30 percent 30 days: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines : 8 C.C.R. 9792.20 - 9792.26. MTUS (Effective July 18, 2009) Page(s): 111-112 of 127.

Decision rationale: Dendracin lotion is a compound of methyl salicylate, menthol, and capsaicin. According to the California Chronic Pain Medical Treatment Guidelines, the only topical analgesic medications indicated for usage include anti-inflammatories, lidocaine, and capsaicin. There is no known efficacy of any other topical agents. Per the MTUS, when one component of a product is not necessary, the entire product is not medically necessary. Additionally, the progress note, dated July 24, 2014, recommended stopping the use of this medication. Considering this, the request for dendracin lotion is not medically necessary.