

<b>Case Number:</b>	CM15-0131630		
<b>Date Assigned:</b>	07/17/2015	<b>Date of Injury:</b>	05/19/2014
<b>Decision Date:</b>	08/21/2015	<b>UR Denial Date:</b>	06/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/07/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 28 year old male with an industrial injury dated 05/19/2014. The injury is documented as occurring as a result of a fall off a ladder resulting in ankle sprain. His diagnosis was talar dome osteochondral defect. Prior treatment included surgery (left repair of the anterolateral ankle ligament). Other treatments included anti-inflammatory medication and physical therapy. He presents on 05/12/2015 with complaints of irritation in the anterolateral aspect of the joint line. Prior surgical incision had healed well. Dorsiflexion stress test was painful. There was no erythema or drainage. The provider documents the injured worker had a lateral posterior 1/3 talar dome osteochondral defect with significant edema in the talus. He had impingement symptoms along the anterolateral aspect. The treatment request is for Dendracin lotion.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Dendracin lotion:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

**Decision rationale:** Regarding request for Dendracin, Dendracin is a combination of methyl salicylate, menthol, and benzocaine. Chronic Pain Medical Treatment Guidelines state that any compounded product that contains at least one drug or drug class that is not recommended, is not recommended. Regarding the use of topical local anesthetics (benzocaine), guidelines state that they are recommended for localized peripheral pain after there is evidence of a trial of first-line therapy. Within the documentation available for review, there is no documentation of localized peripheral pain with evidence of failure of first-line therapy as recommended by guidelines prior to the initiation of topical benzocaine. In the absence of clarity regarding those issues, the currently requested Dendracin is not medically necessary.