

Case Number:	CM14-0183369		
Date Assigned:	11/10/2014	Date of Injury:	09/21/2012
Decision Date:	12/12/2014	UR Denial Date:	10/24/2014
Priority:	Standard	Application Received:	11/04/2014

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 Emergency 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 41-year-old male who reported an injury on 09/21/2012. The mechanism of injury was twisting. The injured worker's diagnoses included lumbar sprain/strain. His past treatments included acupuncture therapy, shockwave treatment and medications. His diagnostic testing included an MRI of the lumbar spine, performed on 02/16/2013, which was noted to reveal multilevel diminished disc height with disc desiccation and bilateral facet arthropathy at L4-5 and L5-S1. Grade 1 retrolisthesis of L5 over S1 was noted. There were no relevant surgeries included in the documentation. On 03/14/2013, the injured worker complained of constant pain in his lower back that he rated a 9/10 on a numeric rating scale. He also reported numbness and tingling that radiated to the left leg. The patient reported that medication only helps cease the pain momentarily. The patient reported that he has been undergoing physiotherapy 2 times a week for the previous 4 weeks and it had been helpful. Upon physical examination of the lumbar spine, the injured worker was noted to have moderate paraspinal tenderness bilaterally with decreased sensation of his left leg. The injured worker was noted with decreased lumbar spine extension limited at 15 degrees with pain. The injured worker's medications included ibuprofen 600 mg, 1 tablet 1 to 2 times per day, and naproxen. The request was for retrospective Dendracin. The rationale for the request was not provided. The Request for Authorization form was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Dendracin (duration and frequency unknown): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

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

Decision rationale: The California MTUS Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety and primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Many agents are compounded as monotherapy or in combination for pain control. There is little to no research to support the use of many of these agents. Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. Dendracin contains methyl salicylates, benzocaine, and menthol. The use of compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. The patient reported a pain 9/10 to this low back, and he reported his medication only gave temporary relief. The documentation did not provide sufficient evidence of tried and failed antidepressants or anticonvulsants as a first line therapy. The documentation did not provide sufficient evidence of significant objective functional deficits. In the absence of documentation with sufficient evidence of significant objective functional deficits and documented evidence of tried and failed anticonvulsants or antidepressants, the request is not supported. Additionally, as the request was written there was no frequency or duration provided. Therefore, the request is not medically necessary.