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| Case Number: | CM15-0118162 | | |
| Date Assigned: | 06/26/2015 | Date of Injury: | 02/16/2005 |
| Decision Date: | 07/31/2015 | UR Denial Date: | 05/19/2015 |
| Priority: | Standard | Application Received: | 06/18/2015 |

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, North Carolina
 Certification(s)/Specialty: Family Practice

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 42 year old male sustained an industrial injury to the low back on 2/16/05. Previous treatment included lumbar fusion (11/4/09), lumbar laminectomy/discectomy (8/14/06), removal of hardware and revision decompression (11/2012), physical therapy, H-wave stimulator, home exercise, injections and medications. In a PR-2 dated 4/29/15, the injured worker complained of low back pain with radiation to bilateral lower extremities, rated 5/10 on the visual analog scale with medications and 10/10 without. The injured worker reported that he continued to see improvement in pain and function with current medications which allowed him to continue to work on a full-time basis. The injured worker stated that he was currently experiencing a flare in symptoms. Physical exam was remarkable for lumbar spine with paraspinous tenderness to palpation from L4 to S1 with decreased range of motion, positive left straight leg raise, 4/5 left extensor hallucis longus strength and hypesthesia in the left L5 distribution. Current diagnoses included lumbar degenerative disc disease, left lower extremity radiculopathy, status post multiple lumbar spine surgeries, bilateral knee pain most likely secondary to altered gait, erectile dysfunction and low testosterone levels. The treatment plan included medications (Norco, Aciphex, Gabapentin, Laxacin and Dendracin lotion) and continuing home exercise.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective (DOS: 4/29/2015) Dendracin lotion 240 ml, 30%/10%/0.025% (two bottles):
Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113.

Decision rationale: The CA MTUS states that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The request is for Dendracin lotion, a topical preparation containing methyl salicylate, menthol and capsaicin. In this case the patient requesting the medication has chronic low back pain and is taking a first-line agent (Gabapentin) for his symptoms. There is no evidence that anti-depressants have been tried and failed for the patient's chronic low back pain. There is no evidence that the dose of Gabapentin has been titrated upwards to reduce his back pain. There are no evidenced-based guidelines which address the use of Dendracin, therefore it is deemed not medically necessary or appropriate.