

<b>Case Number:</b>	CM15-0091319		
<b>Date Assigned:</b>	05/15/2015	<b>Date of Injury:</b>	07/30/2003
<b>Decision Date:</b>	06/16/2015	<b>UR Denial Date:</b>	04/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/12/2015

### 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

### 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 61 year old male, who sustained an industrial injury on 07/30/2003 reporting a right knee injury. On provider visit dated 04/13/2015 the injured worker has reported new injury from right knee given out resulting in a fall striking his right upper arm, right hand and twisting his low back. On examination the left knee revealed tenderness to palpation and an effusion over the peripatellar distribution was noted. Patellofemoral crepitus was noted. Range of motion was decreased. The diagnoses have included left knee patellofemoral arthralgia and severe degenerative joint disease secondary to compensation for altered gait with limp due to right knee condition. Treatment to date has included medication. The provider requested x-ray of the left knee (weight bearing, 2 views) and Dendracin Lotion 120mg.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Dendracin Lotion 120 mg:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines topical salicylate.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, pages 112-113.

**Decision rationale:** Per MTUS Chronic Pain Guidelines, the efficacy in clinical trials for topical analgesic treatment modality has been inconsistent and most studies are small and of short duration. These medications may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. There is little evidence to utilize topical compound analgesic over oral NSAIDs or other pain relievers for a patient with spinal and multiple joint pain without contraindication in taking oral medications. Dendracin's ingredients are methyl salicylate, benzocaine, menthol, capsaicin, dimethyl sulfoxide, aloe vera gel, zingiber extract, borage oil, boswellia serrata, soyalecithin, PEG 100, stearic acid, propylene glycol, cetyl alcohol & Poloxamer 407) is a non-prescription strength topical analgesic with no proven greater efficacy than any other over-the-counter pain cream. Guidelines specifically noted that Boswellia Serrata Resin (Frankincense) is not recommended for chronic pain and as criteria note that any compounded product that contains at least one drug (or drug class) that is not recommended, is therefore, not recommended. Boswellia serrata is not recommended and is also a component of Dendracin, thereby, the request for Dendracin Cream has not been established. Submitted reports have not adequately demonstrated the indication or medical need for this topical analgesic for this chronic injury without documented functional improvement from treatment already rendered. The Dendracin Lotion 120 mg is not medically necessary and appropriate.

**X-ray of the left knee (weight bearing, 2 views):** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): Chapter 13 Knee, Diagnostic Imaging, page 341-343.

**Decision rationale:** Guidelines states that most knee problems improve quickly once any red-flag issues are ruled out. For patients with significant hemarthrosis and a history of acute trauma, radiography is indicated to evaluate for fracture. Reliance only on imaging studies to evaluate the source of knee symptoms may carry a significant risk of diagnostic confusion (false-positive test results). Submitted reports have not adequately demonstrated remarkable clinical findings with evidence of internal derangement, acute flare-up, new injuries, failed conservative knee treatment trial or progressive change to support for the imaging study. The X-ray of the left knee (weight bearing, 2 views) is not medically necessary and appropriate.