

Case Number:	CM13-0044993		
Date Assigned:	12/27/2013	Date of Injury:	09/14/2009
Decision Date:	01/12/2015	UR Denial Date:	09/27/2013
Priority:	Standard	Application Received:	10/31/2013

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 Anesthesiology, has a subspecialty in Pain Management 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:

According to the records made available for review, this is a 59-year-old female with a 9/14/09 date of injury. At the time (9/27/13) of the Decision for Dendracin Lotion 120ml, Flexeril (Cyclobenzaprine) 7.5mg, and Acetadryl (Acetaminophen 500mg/Diphenhydramine 25mg), there is documentation of subjective (low back pain radiating to the lower extremities, headaches, and difficulty sleeping) and objective (tenderness to palpation over the lumbar spine and painful range of motion) findings, current diagnoses (status post L3-L5 posterior lumbar decompression, disc herniation at L3-L4, and chronic pain syndrome), and treatment to date (epidural injections and medications (including ongoing treatment with Flexeril, Anaproxen, and Dendracin Lotion since at least 5/2/13)). Medical reports identify a request for Acetadryl (Acetaminophen 500mg/Diphenhydramine 25mg) 50 pieces 2 bottles. Regarding Flexeril (Cyclobenzaprine) 7.5mg, there is no documentation of short-term (less than two weeks) treatment of acute low back pain; for short-term treatment of acute exacerbations in patients with chronic low back pain; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Flexeril use to date. Regarding Acetadryl (Acetaminophen 500mg/Diphenhydramine 25mg), there is no documentation of the intention to treat insomnia over short period.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETRO DENDRACIN LOTION 120ML, APPLIED TOPICALLY 2-3 TIMES A DAY AS NEEDED #1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 28-29, 105.

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

Decision rationale: Dendracin (Capsaicin/Menthol/Methyl Salicylate/ Benzocaine) is a topical analgesic used for temporary relief of minor aches and pains caused by arthritis, simple backache, and strains. MTUS Chronic Pain Medical Treatment Guidelines identifies documentation that many agents are compounded as monotherapy or in combination for pain control; that ketoprofen, lidocaine (in creams, lotion or gels), capsaicin in a 0.0375% formulation, baclofen and other muscle relaxants, and gabapentin and other antiepilepsy drugs are not recommended for topical applications; and that any compounded product that contains at least one drug (or drug class) that is not recommended, is not recommended. Within the medical information available for review, there is documentation of diagnoses of status post L3-L5 posterior lumbar decompression, disc herniation at L3-L4, and chronic pain syndrome. However, Dendracin contains at least one drug (capsaicin) that is not recommended. Therefore, based on guidelines and a review of the evidence, the request for Dendracin Lotion 120ml is not medically necessary.

RETRO FLEXERIL (CYCLOBENZAPRINE) 7.5MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MUSCLE RELAXANTS (FOR PAIN)/ANTISPASMODICS Page(s): 64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 41-42. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Muscle relaxants (for pain) Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that Flexeril is recommended for a short course of therapy. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies that muscle relaxants are recommended as a second line option for short-term (less than two weeks) treatment of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Within the medical information available for review, there is documentation of diagnoses of post L3-L5 posterior lumbar decompression, disc herniation at L3-L4, and chronic pain syndrome. In addition, there is documentation of ongoing treatment with Flexeril and Flexeril used as a second line option. However, there is no documentation of muscle spasm. In addition, given documentation of records reflecting prescription for Flexeril since at least 5/2/13, there is no documentation of short-term (less than two weeks) treatment of acute low back pain; for short-term treatment of acute exacerbations in patients with chronic low back pain; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance;

and/or a reduction in the use of medications as a result of Flexeril use to date. Therefore, based on guidelines and a review of the evidence, the request for Flexeril (Cyclobenzaprine) 7.5mg is not medically necessary.

**RETRO ACETADRYL (ACETAMINOPHEN 500MG/DIPHENHYDRAMINE 25MG) #50
2 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), Pain, Insomnia treatment

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Acetaminophen (APAP) Page(s): 11-12. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, antihistamines are not recommended for long-term insomnia treatment. Other Medical Treatment Guideline or Medical Evidence:
(<http://dailymed.nlm.nih.gov/dailymed/archives/fdaDrugInfo.cfm?archiveid=59548>)

Decision rationale: An online search identifies that Acetadryl contains Acetaminophen and Diphenhydramine and is indicated for relief of occasional headaches and minor aches/pains with accompanying sleeplessness. MTUS does not address Diphenhydramine. MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of chronic pain or acute exacerbations of chronic pain, as criteria necessary to support the medical necessity of Acetaminophen. ODG identifies that antihistamines are not recommended for long-term insomnia treatment. Within the medical information available for review, there is documentation of diagnoses of post L3-L5 posterior lumbar decompression, disc herniation at L3-L4, and chronic pain syndrome. In addition, there is documentation of headaches. However, given documentation of difficulty sleeping and a request for Acetadryl (Acetaminophen 500mg/Diphenhydramine 25mg) 50 pieces 2 bottles, there is no documentation of the intention to treat insomnia over short period. Therefore, based on guidelines and a review of the evidence, the request for Acetadryl (Acetaminophen 500mg/Diphenhydramine 25mg) is not medically necessary.