

Case Number:	CM13-0026152		
Date Assigned:	02/03/2014	Date of Injury:	03/21/2003
Decision Date:	05/23/2014	UR Denial Date:	08/28/2013
Priority:	Standard	Application Received:	09/18/2013

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 Occupational 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:

According to the records made available for review, this is a 54-year-old male with a 3/21/03 date of injury. At the time (8/14/13) of request for authorization for Ketamine 5% 60gr # 2 and Diclofenac Sodium 1.5% 60 GM, #1, there is documentation of subjective (back and leg pain, right shoulder pain, and peptic ulcer disease for which using a proton pump inhibitor) and Objective (antalgic gait) findings, current diagnoses (peptic ulcer disease, lumbar spinal stenosis, sciatica, and sacrum disorders), treatment to date (medications (including ongoing treatment with Ketamine 5% cream)). Medical report identifies that patient cannot use oral anti-inflammatory medication and is requesting a topical. Regarding Diclofenac Sodium 1.5% 60 GM, #1, there is no documentation of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist), intention for short-term use (4-12 weeks), and used as second line treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

DICLOFENAC SODIUM 1.5% 60 GM, #1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NON STEROIDAL ANTI-INFLAMMMATORY AGENT Page(s): 111-112. Decision based on Non-

MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) PAIN, DICLOFENAC SODIUM

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist) and short-term use (4-12 weeks), as criteria necessary to support the medical necessity of Diclofenac Sodium 1.5%. The Official Disability Guidelines (ODG) identifies documentation of failure of an oral non-steroidal anti-inflammatory drug (NSAID) or contraindications to oral NSAIDs and documentation of use as a second line treatment, as criteria necessary to support the medical necessity of Diclofenac Sodium Gel. Within the medical information available for review, there is documentation of diagnoses of lumbar spinal stenosis, sciatica, and sacrum disorders. In addition, there is documentation that the patient cannot use oral anti-inflammatory medication and is requesting a topical. However, there is no documentation of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist), intention for short-term use (4-12 weeks), and use as second line treatment. Therefore, based on guidelines and a review of the evidence, the request cannot be supported. The request for Diclofenac Sodium 1.5% 60 gm, #1 is not medically necessary and appropriate.

PRILOSEC DR 20 MG, #60 WITH 3 REFILLS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines KETAMINE Page(s): 56.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that Ketamine is not recommended. There is insufficient evidence to support the use of ketamine for the treatment of chronic pain. MTUS Chronic Pain Medical Treatment Guidelines additionally identify that there are no quality studies that support the use of ketamine for chronic pain, but it is under study for complex regional pain syndrome (CRPS). Therefore, based on guidelines and a review of the evidence, the request for Ketamine 5% 60gr # 2 is not medically necessary.