

Case Number:	CM14-0127153		
Date Assigned:	08/13/2014	Date of Injury:	06/11/2001
Decision Date:	10/03/2014	UR Denial Date:	07/29/2014
Priority:	Standard	Application Received:	08/11/2014

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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in California and Nevada. 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 60 year old female who is reported to have sustained injuries to her low back as a result of a motor vehicle accident occurring on 06/11/01. The record indicates that the injured worker underwent a lumbar discectomy (level unknown) in 2005. She continues to have low back pain with radiation to the left lower extremity. Per physical examination dated 04/28/14, she has decreased range of motion, a positive straight leg raise on the left, decreased motor strength in left foot dorsa flexion, and decreased sensation in the left lateral calf. She is noted to have undergone an electromyogram (EMG) / Nerve conduction velocity (NCV) of the bilateral lower extremities on 09/27/06 reported as normal. The record indicates that the injured worker underwent a magnetic resonance imaging (MRI) of the lumbar spine on 08/21/12 which shows multi-level disc protrusions and degenerative changes. The injured worker's current medication profile includes Pantoprazole, Methadone 5mg, Hydrocodone 10/325mg, Gabapentin 600mg, Topamax 100mg, Lidocaine 5% patch, and topical creams. The record contains a single urine drug screen dated 03/31/14 which reflects that the injured worker is compliant with her medication profile. The record includes a utilization review determination dated 07/29/14 in which requests for Hydrocodone/APAP 10/325mg #180, Tizanidine 4mg #90, Lidoderm 5% patch 700mg #90 with 5 refills, Capzasin 0.075% cream #1, and Ketamine 60 grams #1 was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone/APAP 10/325mg #180: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opiates Page(s): 74-80.

Decision rationale: The request for Hydrocodone/APAP 10/325mg #180 is not supported as medically necessary. The submitted clinical records indicate that the injured worker has a failed back surgery syndrome. She is noted to be maintained on Methadone 5mg as well as Hydrocodone 10/325mg. The submitted clinical records provide no data which establishes that the injured worker has a signed pain management contract. The record provides no information to establish the efficacy of these medications. The record does not contain any visual analog scale (VAS) scores or other data establishing that the injured worker receives functional benefits from this medication. Therefore, noting the lack of supporting data, the continued use of this medication is not established as medically necessary.

Tizanidine 4mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-66.

Decision rationale: The request for Tizanidine 4mg #90 is not supported as medically necessary. The submitted clinical records indicate that the injured worker has an apparent failed back surgery syndrome. She continues to have low back pain with radiation to the left lower extremity. There is evidence of an active lumbar radiculopathy. The most recent detailed physical examination is from April. This examination does not document the presence of muscle spasms on examination. Therefore, the continued use of Tizanidine 4mg is not established as medically necessary.

Lidoderm %5 patch 700mg #90 with 5 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (Lidocaine).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines Lidoderm (lidocaine patch), Page(s): Page 56-57.

Decision rationale: The request for Lidoderm 5% patch 700mg #90 with 5 refills is not supported as medically necessary. The submitted clinical records indicate that the injured worker has a failed back surgery syndrome and evidence of myofascial pain. However, the record provides no data establishing that the injured worker has failed trials of other medications. Further, the record provides no data which establishes the benefit of Lidoderm patch. There is no

documentation of functional improvements as a result and therefore, medical necessity is not established.

Capsaicin 0.075% cream #1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-114..

Decision rationale: The request for Capzasin 0.075% cream #1 is not supported as medically necessary. The record indicates that the injured worker has myofascial pain in conjunction with a failed back surgery syndrome. The record does not provide any specific instructions on the use of this topical analgesic. As such, the medical necessity for continued use is not established.

Ketamine %60gr#1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines Topical Analgesics Page(s): 111-114. Decision based on Non-MTUS Citation Pain Chapter, Compounded Medications

Decision rationale: The request for Ketamine 60 grams #1 is not supported as medically necessary. The submitted clinical records indicate that the injured worker has a failed back surgery syndrome as well as myofascial pain. California Medical Treatment Utilization Schedule, The Official Disability Guidelines and US Food and Drug Administration (FDA) do not recommend the use of compounded medications as these medications are noted to be largely experimental in use with few randomized controlled trials to determine efficacy or safety. Further, the FDA requires that all components of a transdermal compounded medication be approved for transdermal use. This compound contains: Ketamine which has not been approved by the FDA for transdermal use. Any compounded product that contains at least one drug (or drug class) that is not recommended and therefore not medically necessary.