MAXIMUS Federal Services

Case Number:	CM14-0134946		
Date Assigned:	08/27/2014	Date of Injury:	02/05/2005
Decision Date:	09/26/2014	UR Denial Date:	08/04/2014
Priority:	Standard	Application Received:	08/20/2014

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 Emergency Medicine and is licensed to practice in Texas. 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 27-year-old male who reported an injury on 02/05/2005. The mechanism of injury was due to continuous lifting of doors which consisted of 50 to 60 pounds. The injured worker has a diagnosis of lumbar disc displacement without myelopathy. Past treatments consisted of physical therapy, the use of a TENS unit, lumbar epidural steroid injections, and medication therapy. Medications included diclofenac sodium, ketamine, orphenadrine-Norflex, Advair, aspirin, clozapine, metformin, simvastatin, benazepril, Dexilant, docusate, bupropion, and albuterol. An MRI of the lumbar spine showed left neural foraminal annular fissure and disc protrusion causing narrowing of the infra neural foramen and lateral recess at L4-5. An EMG of the lumbar spine showed that the injured worker was negative for radiculopathy. On 07/11/2014, the injured worker complained of lower back pain. The physical examination revealed that the injured worker had normal muscle tone without atrophy in the right upper extremity, normal muscle tone without atrophy in the left upper extremity, normal muscle tone without atrophy in the right lower extremity, and normal muscle tone without atrophy in the left lower extremity. The submitted report lacked any indication of range of motion, motor strength, or sensory deficits. The treatment plan was for the injured worker to continue the use of diclofenac sodium and ketamine cream. The provider feels the continuation of conservative management and the use of a TENS unit, with the continuation of ketamine cream and diclofenac sodium is necessary. The Request for Authorization form was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Diclofenac Sodium 1.5% #60g (date of service 6/11/14): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non-steroidal antiinflammatory agents (NSAIDs) Page(s): 111.

Decision rationale: The request for diclofenac sodium 1.5% is not medically necessary. Diclofenac, the equivalent to Pennsaid, is recommended for osteoarthritis after a failure of an oral NSAID or contraindications to oral NSAIDs, and after considering the increased risk profile with diclofenac, including topical formulations for the treatment of the signs and symptoms of osteoarthritis of the lower back. Diclofenac would be recommended for the treatment of osteoarthritis and tendinitis of the knee, elbow, or other joints that are amenable to topical treatment. The included medical documentation lacked evidence of the injured worker having any contraindications to oral pain medications and also lacked evidence that these medications failed to meet the provider's expectations of pain relief. Furthermore, the submitted report did not indicate that the injured worker had a diagnosis of osteoarthritis. Additionally, the request as submitted lacked an indication as to where the medication cream would be used. Given the above, and that the submitted request did not specify a duration or a frequency of the medication, the request for diclofenac sodium is not medically necessary.

Ketamine 5% cream #60g (date of service 6/11/14): Upheld

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

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

Decision rationale: The request for ketamine 5% cream is not medically necessary. The California MTUS Guidelines state ketamine is currently under study: only recommended for the treatment of neuropathic pain in refractory cases in which all primary and secondary treatments have been exhausted. The submitted documentation lacked any evidence of the injured worker having exhausted primary and secondary treatment. The documentation submitted for review also lacked any indication that the injured worker had a diagnosis of neuropathic pain. Given the above, the injured worker is not within the MTUS Guidelines. As such, the request for ketamine 5% cream is not medically necessary.