

Case Number:	CM14-0178769		
Date Assigned:	10/31/2014	Date of Injury:	02/15/2006
Decision Date:	12/08/2014	UR Denial Date:	10/27/2014
Priority:	Standard	Application Received:	10/27/2014

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 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 48-year-old male with a 2/15/06 date of injury. At the time (9/4/14) of request for authorization for Retrospective request for pharmacy purchase of Ketamine 5% 60 mg # 2, DOS 9/4/14, Retrospective request for Zaleplon 10 mg # 30, with one refill, DOS 9/4/14, and Retrospective request for Doxelpin 3.3 cream 60 gm # 1, DOS 9/4/14, there is documentation of subjective (chronic low back pain radiating to leg, burning right knee pain with numbness/tingling, burning left lateral thigh pain, and sleeplessness) and objective (tenderness over lumbosacral junction, decreased lumbar range of motion, decreased sensory exam over right leg, and antalgic gait) findings, current diagnoses (lumbar disc displacement, lumbar disc degeneration, and cervical disc displacement), and treatment to date (medications (including ongoing treatment with Ketamine cream, Norco, Zaleplon since at least 3/20/14, Nabumentone, Doxepin, and Cyclobenzaprine)). 10/15/14 medical report identifies that patient has tried and failed oral medications including anti-depressants (Mirtazapine and Cymbalta), opioids (Tramadol and Buprenorphine), NSAIDs (Etodolac), and muscle relaxants (Zanaflex); Ketamine and Dexelpin creams help reduce pain and allow greater function; and that Zaleplon helps patient to sleep better. Regarding Retrospective request for pharmacy purchase of Ketamine 5% 60 mg # 2, DOS 9/4/14, , there is no documentation 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 as a result of Ketamine cream use to date. Regarding Retrospective request for Zaleplon 10 mg # 30, with one refill, DOS 9/4/14, there is no documentation of the intention to treat over a short-term (up to 7-10 days); 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 Zaleplon use to date. Regarding Retrospective request for Doxelpin 3.3 cream 60 gm # 1, DOS 9/4/14, there is no

documentation 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 as a result of Doxelpin cream use to date.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for pharmacy purchase of Ketamine 5% 60 mg # 2, DOS 9/4/14:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 113. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment guideline identifies documentation of neuropathic pain when all primary and secondary options have been exhausted, as criteria necessary to support the medical necessity of topical ketamine. 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. Within the medical information available for review, there is documentation of diagnoses of lumbar disc displacement, lumbar disc degeneration, and cervical disc displacement. In addition, there is documentation of ongoing treatment with Ketamine cream. Furthermore, given documentation of subjective (burning right knee pain with numbness/tingling and burning left lateral thigh pain) findings, and that patient has tried and failed oral medications including anti-depressants (Mirtazapine and Cymbalta), opioids (Tramadol and Buprenorphine), NSAIDs (Etodolac), and muscle relaxants (Zanaflex), there is documentation of neuropathic pain; and all primary and secondary options have been exhausted. However, despite documentation that Ketamine cream helps reduce pain and allow greater function, there is no (clear) documentation 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 as a result of Ketamine cream use to date. Therefore, based on guidelines and a review of the evidence, the request for Retrospective request for pharmacy purchase of Ketamine 5% 60 mg # 2, DOS 9/4/14 is not medically necessary.

Retrospective request for Zaleplon 10 mg # 30, with one refill, DOS 9/4/14: 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 Chapter

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain

Chapter, Insomnia treatment Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS does not address this issue. ODG identifies documentation of insomnia and the intention to treat over a short-term (7-10 days), as criteria necessary to support the medical necessity of Zaleplon (Sonata). 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. Within the medical information available for review, there is documentation of diagnoses of lumbar disc displacement, lumbar disc degeneration, and cervical disc displacement. In addition, there is documentation of ongoing treatment with Zaleplon. However, given documentation of records reflecting prescriptions for Zaleplon since at least 3/20/14, there is no documentation of the intention to treat over a short-term (up to 7-10 days). In addition, despite documentation that Zaleplon helps patient to sleep better, there is no (clear) documentation 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 as a result of Zaleplon use to date. Therefore, based on guidelines and a review of the evidence, the request for Retrospective request for Zaleplon 10 mg # 30, with one refill, DOS 9/4/14 is not medically necessary.

Retrospective request for Doxelpin 3.3 cream 60 gm # 1, DOS 9/4/14: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13-14. Decision based on Non-MTUS Citation 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 documentation of chronic pain, as criteria necessary to support the medical necessity of antidepressants. In addition, MTUS Chronic Pain Medical Treatment Guidelines identifies tricyclic antidepressants as first-line agent unless they are ineffective, poorly tolerated, or contraindicated. 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. Within the medical information available for review, there is documentation of diagnoses of lumbar disc displacement, lumbar disc degeneration, and cervical disc displacement. In addition, there is documentation of chronic pain; and ongoing treatment with Doxelpin cream. Furthermore, given documentation that patient has tried and failed oral medications including anti-depressants (Mirtazapine and Cymbalta), there is documentation antidepressants are ineffective. However, despite documentation that Doxelpin cream helps reduce pain and allow greater function, there is no (clear) documentation 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 as a result of Doxelpin cream use to date. Therefore, based

on guidelines and a review of the evidence, the request for Retrospective request for Doxelpin 3.3 cream 60 gm # 1, DOS 9/4/14 is not medically necessary.