

Case Number:	CM14-0027199		
Date Assigned:	06/13/2014	Date of Injury:	03/05/2007
Decision Date:	07/28/2014	UR Denial Date:	02/27/2014
Priority:	Standard	Application Received:	03/03/2014

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 Orthopaedic Surgery and is licensed to practice in Mississippi. 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 37-year-old female who was reportedly injured on March 5, 2007. The mechanism of injury was noted as a student slamming a calculator on the employee's left hand, eventually resulting in complex regional pain syndrome of all extremities. The most recent progress note dated June 11, 2014, indicated there were ongoing complaints of severe pain of the upper and the lower extremities and "burning fire" pain in the upper and lower extremities tremors. The physical examination demonstrated the patient with an antalgic gait and used a four pronged cane. Strength was equal and symmetric in the upper and lower extremities 4/5. Reflexes are 2+ and symmetric in the upper and lower extremities. The patient has bilateral upper extremity resting tremors. Sensation was intact to light touch; however, there was hypersensitivity throughout the upper and lower extremities worse on the dorsum of her feet. Diagnostic imaging studies are referenced, however the formal report is not presented for review. Previous treatment included spinal dorsal column stimulator, intrathecal pump implant (x2), multiple medications including methadone, Neurontin, Celebrex, Remeron, levorphanol, Cymbalta, EMLA cream, pool therapy desensitization program, pain psychologist. A request had been made for outpatient ketamine infusions a series of 10, levorphanol, methadone 5 mg, EMLA cream, Neurontin 600 mg, Neurontin 900 mg, Cymbalta 50 mg, Remeron 15 mg and were not certified in the pre-authorization process on February 27, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

KETAMINE INFUSIONS, SERIES OF 10: 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: As noted in the MTUS, this medication is not recommended as there is insufficient evidence to support the use for in a chronic pain patient. Furthermore, as noted in the progress notes presented for review, there is no objectified efficacy or utility for this preparation. The pain continued at the same levels. There is no improved functionality, ability to return to work and multiple other narcotic medications were required. Therefore, based on the clinical information presented and by the guidelines noted, this request is not medically necessary.

LEVORPHANOL 2 MG QTY #168 REFILLS: 0: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 75-78.

Decision rationale: Levopharnol is a potent narcotic similar to morphine. The patient currently is being treated with intrathecal pump containing morphine. Due to the lack of improvement and response to treatment, the lack of return to work, MTUS guidelines state the use of long-term narcotics is not indicated. Therefore, it is not medically necessary.

METHADONE 5 MG QTY #84 REFILLS: 0: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Methadone Page(s): 61-62.

Decision rationale: Based on the mechanism of injury, current interventions in the California MTUS Guidelines note methadone is used as a second line drive treatment for moderate to severe pain and for ongoing management. There should be documentation of the four A's including analgesia, activities of daily living, adverse side effects and monitoring of the aberrant drug taking behavior. The patient currently has been on intrathecal pain pump that includes morphine, fentanyl, baclofen and bupivacaine. The patient is also taking Neurontin and levorphanol and Actiq. There is lack of documentation of functioning improvement and objective decrease in pain scores or any monitoring of aberrant drug seeking behavior therefore this request is not medically necessary.

EMLA CREAM FOR INTRATHECAL PUMP REFILLS- QTY 3: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: EMLA is a lidocaine cream which has a limited indication, a localized peripheral pain scenario, and when noting the limited efficacy reported, there is no objectified clinical indication for the continued use of this preparation. Furthermore, when noting the generalized pain complaints, this is clearly outside the reach of this medication. Accordingly, there is no clinical indication for the use of this medication and therefore it is not medically necessary.

NEURONTIN 600 MG QTY #90 (3 MONTH SUPPLY) REFILLS: 0: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain Page(s): 60.

Decision rationale: The literature supports that this medication has been shown to be effective for treatment of diabetic painful neuropathy and post herpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. None of these diagnoses are present based on the records presented for review. Furthermore, a review of the notes does not establish any efficacy or utility with this medication. Therefore, there is no objectified clinical indication presented for the use of this medication, and therefore the request is not medically necessary.

NEURONTIN 900 MG QTY #270 (3 MONTH SUPPLY) REFILLS: 0: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) and Gabapentin (Neurontin) Page(s): 16-20 and 49.

Decision rationale: Gabapentin is considered a first-line treatment for neuropathic pain. Based on the clinical documentation provided, there is no evidence of neuropathic type pain or radicular pain on exam or subjectively. As such, without any evidence of neuropathic type pain, the medication is not medically necessary.

CYMBALTA 60 MG QTY #90 (3 MONTH SUPPLY) REFILLS: 0: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cymbalta Page(s): 42.

Decision rationale: Cymbalta is a selective serotonin and norepinephrine reuptake inhibitor. It is recommended as a first-line option for diabetic neuropathy. Though increasing off label use of this medication exists for various pain syndromes. The current clinical indications are for anxiety, depression, diabetic neuropathy and fibromyalgia. When noting that the record is unclear if the medication is being used to treat chronic pain or symptoms of depression, therefore, it is not medically necessary.

REMERON 15 MG QTY #180 (3 MONTH SUPPLY) REFILLS: 0: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tricyclics Page(s): 122.

Decision rationale: Remeron is a tetracyclic anti-depressant used in the treatment of major depressive disorder and other mood disorders. Sometimes, it is used as a sleep agent; however, it is short term. There is no clear documentation why this agent is being used, if for the noted chronic pain syndrome. Furthermore, the use of such a medication is indicated for short-term (or temporary) applications. Therefore, there is no clinical indication to support any efficacy or utility. As such, this is not medically necessary.