MAXIMUS Federal Services

Case Number:	CM14-0031734		
Date Assigned:	06/20/2014	Date of Injury:	04/27/2004
Decision Date:	07/22/2014	UR Denial Date:	02/22/2014
Priority:	Standard	Application Received:	03/13/2014

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 Physical Medicine and Rehabilitation, and is licensed to practice in Minnesota. 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 52-year-old female who reported an injury 04/27/2004. The mechanism of injury was not provided within the medical records. The clinical note dated 04/28/2014 indicated the injured worker reported low back pain described as pinching that radiated in the right buttock. The injured worker reported she underwent a lumbar radiofrequency ablation on 01/14/2014. The injured worker reported a flare-up of back pain after the procedure. The injured worker reported her pain was worse at night; however, the injured worker reported the use of medication alleviated her pain. The injured worker reported her pain improved by 60% with the use of medication. She reported her pain was 6/10. The injured worker reported Flector patches helped. The injured worker denied side effects. On physical examination, motor strength was normal. Sensation was intact. The injured worker's prior treatments included diagnostic imaging, surgery, and medication management. The injured worker's medication regimen included Lidoderm, Flector, nabumetone-Relafen, gabapentin, ketamine, Lactulose, cyclobenzaprine-Flexeril, and Prilosec. The provider submitted a request for ketamine, Lidoderm, Flexeril, Lactulose, gabapentin, and cyclobenzaprine. A request for authorization was not submitted for review to include the date the treatment was requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prescription of Ketamine 60gr: 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 Topical Analgesic, page113 Page(s): 113.

Decision rationale: The request for Ketamine 60gr is non-certified. The California Chronic Pain Medical Treatment Guidelines state Ketamine is under study and only recommended for treatment of neuropathic pain in refractory cases in which all primary and secondary treatment has been exhausted. Topical ketamine has only been studied for use in non-controlled studies for CRPS I (complex regional pain syndrome) and post-herpetic neuralgia and both have shown encouraging results. The exact mechanism of action remains undetermined. The record did not clearly reflect neuropathic symptoms. It was not indicated that the injured worker had exhausted other primary and secondary treatments. In addition, the documentation submitted did not indicate the injured worker had findings that would suggest she was at risk for complex regional pain syndrome or postherpetic neuralgia. Furthermore, the request did not provide a frequency for the medication. Therefore, the request for ketamine isnot medically necessary.

Prescription for Lidoderm 5% patch: 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, Lidoderm.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesic, page 112 Page(s): 112.

Decision rationale: The request for Lidoderm 5% patch is non-certified. The California Chronic Pain Medical Treatment Guidelines state that Lidoderm is recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy. There was lack of evidence in the documentation of neuropathic pain. In addition, the documentation submitted did not indicate any evidence of first line therapy. Furthermore, the request did not provide a frequency or quantity for the medication. Therefore, the request for Lidoderm 5% is not medically necessary.

Prescription for Flector Patch 1.3%: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSAIDs. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Flector Patch.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesic, page 112 Page(s): 112.

Decision rationale: The request for Flector Patch 1.3% is non-certified. The California Chronic Pain Medical Treatment Guidelines states Flector is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has

not been evaluated for treatment of the spine, hip or shoulder. The documentation submitted did not indicate the injured worker had findings that would support she was at risk for osteoarthritis. In addition, there was lack of documentation of efficacy and functional improvement with this medication. Furthermore, the request did not provide a frequency or quantity for this medication. Therefore, the request for Flector patch 1.3% is not medically necessary.

Prescription of Lactulose 10gr/15ml sol 10grma/15ml: 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), Opioid Induced constipation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use, Initiating therapy Page(s): 77.

Decision rationale: The request for Lactulose 10gr/15ml sol 10grma/15ml is non-certified. The California Chronic Pain Medical Treatment Guidelines state prophylactic treatment of constipation should be initiated. The documentation submitted did not indicate the injured worker had findings that would support she was at risk for constipation. In addition, there was lack of documentation of efficacy and functional improvement of this medication. Furthermore, the request did not indicate a frequency or quantity for this medication. Therefore, the request for Lactulose 10 g/mL solution is not medically necessary.

Prescription of Gabapentin 600mg, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs (AEDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Specific Anti-epilepsy Drugs, page(s) 18 Page(s): 18.

Decision rationale: The request for of Gabapentin 600mg, #60 is non-certified. The California Chronic Pain Medical Treatment Guidelines The guidelines note Gabapentin 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. The documentation submitted did not indicate the injured worker had findings that would support she was at risk for diabetic painful neuropathy or postherpetic neuralgia. In addition, there was lack of evidence the injured worker had neuropathic pain. Furthermore, the request did not indicate a frequency for this medication. Therefore, the request for Gabapentin 600 mg 60 tablets is not medically necessary.

Prescription of Cyclobenzaprine-flexeril: 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 relaxant Page(s): 64.

Decision rationale: The request for Cyclobenzaprine-Flexeril is non-certified. The California Chronic Pain Medical Treatment Guidelines recommend Cyclobenzaprine-Flexeril for a short course of therapy. Cyclobenzaprine-Flexeril is effective in the management of back pain and fibromyalgia. The injured worker has been prescribed this medication since at least 01/06/2014. This exceeds the guideline recommendation for a short course of therapy. In addition, there is lack of documentation of efficacy of this medication. Furthermore, the request does not indicate a dosage, frequency or quantity for the medication. Therefore, the request for a Cyclobenzaprine-Flexeril, is not medically necessary.