

Case Number:	CM14-0052723		
Date Assigned:	07/07/2014	Date of Injury:	02/12/1993
Decision Date:	08/27/2014	UR Denial Date:	04/07/2014
Priority:	Standard	Application Received:	04/21/2014

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 & Rehabilitation, and is licensed to practice in 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 53-year-old female who was reportedly injured on 2/12/1993. The mechanism of injury was noted as a lifting injury. The most recent progress note dated 3/10/2014, indicated that there were ongoing complaints of neck pain shoulder pain, ankle pain, and depression. The physical examination demonstrated the injured employee to be awake, alert, no acute distress. Extremities were well perfused and restoration was non-labor. Muscle strength 5/5 bilateral upper extremity. No recent diagnostic studies are available for review. Previous treatment included placement of spinal cord stimulator, injections, medications, and conservative treatment. A request had been made for Morphine Sulphate Contin 15mg #90, Percocet 5/325mg #60, Ketamine/Ketoprofen/Lidocaine Topical Cream was not certified in the pre-authorization process on 4/7/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

MS contin 15mg #90; 1 refill: 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 8 C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009) Page(s): 74-75, 78, 93 OF 127.

Decision rationale: California Medical Treatment Utilization Schedule guidelines support long-acting opiates in the management of chronic pain when continuous around-the-clock analgesia is needed for an extended period of time. Management of opiate medications should include the lowest possible dose to improve pain and function, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The claimant suffers from chronic pain; however, there is no documentation of improvement in the pain level or function with the current treatment regimen. In the absence of subjective or objective clinical data, this request is not medically necessary.

Percocet 5/325 #60; 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 79, 80, 81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009) Page(s): 74, 78, 93 OF 127.

Decision rationale: California Medical Treatment Utilization Schedule supports short-acting opiates for the short-term management of moderate to severe breakthrough pain. Management of opiate medications should include the lowest possible dose to improve pain and function, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The claimant suffers from chronic pain; however, there is no clinical documentation of improvement in the pain or function with the current regimen. As such, this request is not medically necessary.

Topical Keramine cream (ketamine/ketoprofen/lidocaine 5.525g/2.48gm/114gm topical cream): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 117-119. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009) Page(s): 111-113.

Decision rationale: California Medical Treatment Utilization Schedule guidelines state that topical analgesics are largely experimental, and that any compound product, that contains at least one drug (or drug class), that is not recommended, is not recommended. The guidelines note there is little evidence to support the use of topical compounding cream pain. Furthermore, there is no documentation of any conservative treatment, physical therapy or first-line medications. As such, this request is not medically necessary.