

Case Number:	CM14-0087985		
Date Assigned:	07/23/2014	Date of Injury:	06/30/1995
Decision Date:	08/29/2014	UR Denial Date:	05/09/2014
Priority:	Standard	Application Received:	06/11/2014

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 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:

The injured worker is a 59-year-old male who reported an injury on 06/30/1995. The mechanism of injury was noted to be cumulative trauma. His diagnoses were noted to be status post repetitive strain injury of extremity; status post bilateral carpal tunnel and radial tunnel release; degenerative disc disease of the lumbar spine; chronic pain syndrome; partial rotator cuff tear of left shoulder with associated tendinopathy; probable impingement syndrome; and degenerative arthritis of right shoulder. Prior treatments were noted to be epidural steroid injections, trigger point injections, medications, and therapy. Diagnostics included an MRI. The injured worker was seen for a clinical evaluation on 05/08/2014 with complaints of right shoulder pain and low back pain. The objective findings included no swelling or tenderness to palpation in any extremity. Muscle tone was slightly impaired in the right upper extremity, but without atrophy. The injured worker was noted to not exhibit acute distress, anxiety, confusion, fatigue, lethargy, pain, tearfulness, or suicidal ideation. His medications were noted to be ketamine cream, Cymbalta, OxyContin, and naproxen. The treatment plan was for medication and a followup appointment. The provider's rationale for the request was provided within the clinical treatment plan. The Request for Authorization Form was provided for the OxyContin request and dated 05/08/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ketamine 5% cream 60 gram; Dispensed 03/24/2014: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines EVIDENCE CITATIONS FOR TOPICAL MEDICATION.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: The request for Ketamine 5% cream 60 gram; Dispensed 03/24/2014 is non-certified. The California MTUS Chronic Pain Medical Treatment Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. These are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Topical ketamine has only been studied for use in non-controlled studies for complex regional pain syndrome and postherpetic neuralgia, and both have shown encouraging results. The exact mechanism of action remains undetermined. The documentation provided for review does not indicate failed therapy of antidepressants or anticonvulsants. The injured worker does not have a complex regional pain syndrome or postherpetic neuralgia diagnosis. The provider's request fails to indicate a dosage frequency. Therefore, the request for Ketamine 5% cream 60 gram; Dispensed 03/24/2014 is non-certified.

Oxycontin 60 mg Qty: 120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management Page(s): 78.

Decision rationale: The request for Oxycontin 60 mg Qty: 120 is non-certified. The California MTUS Chronic Pain Medical Treatment Guidelines provide 4 domains that are relevant for ongoing monitoring of chronic pain patients on opioids. These include pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potential aberrant (or non-adherent) drug related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors). Monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. The documentation provided for review does not provide an adequate pain assessment. Pain assessment should include current pain; the least reported pain over the period since the last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. In addition, the provider's request fails to provide a frequency. Therefore, the request for Oxycontin 60 mg Qty: 120 is non-certified.