

Case Number:	CM14-0094619		
Date Assigned:	08/04/2014	Date of Injury:	01/01/1998
Decision Date:	09/30/2014	UR Denial Date:	05/29/2014
Priority:	Standard	Application Received:	06/20/2014

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 Family Medicine and is licensed to practice in Tennessee, Florida and 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 55 year old female who reported an injury on 01/01/98 as a result of repetitive stress to the neck and upper back with subsequent C5-6 anterior discectomy and fusion on 11/25/98. Utilization review treatment appeal dated 06/06/14 indicated the injured worker continued to complain of neck and back pain with no significant changes in complaints. The injured worker also continued to complain of neck pain with radiation of the left upper extremity in the C7 distribution. The injured worker also reported numbness and tingling in the same distribution. Pain worsened with activity using upper extremities. The injured worker also reported low back pain worsened with bending and walking improved with medications. Physical examination revealed ambulation without assistance, paravertebral muscle tenderness and hypertonicity, trapezius muscle tenderness and hypertonicity. Documentation indicated the injured worker utilized Capsaicin and Ketamine which brought down pain level from 8/10 to 5-6/10 on VAS. The injured worker able to sleep 4-5 hours per night and tolerate activities such as laundry, cooking, and shopping. Additional medications include Lidocaine 5% ointment, Lactulose, Lunesta, Soma, Hydrocodone-Acetaminophen, Topamax, Lasix and Atenolol. The initial request for Capsaicin 0.075% cream #2 and Ketamine 5% cream (RX 05/05/14) was initially non-certified on 05/29/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Capsaicin 0.075% Cream #2 (Rx 05/05/14): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Capsaicin, topical Page(s): 28.

Decision rationale: As noted on page 28 of the Chronic Pain Medical Treatment Guidelines, capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. There are positive randomized studies with capsaicin cream in patients with osteoarthritis, fibromyalgia, and chronic non-specific back pain, but it should be considered experimental in very high doses. There is no indication in the documentation that the injured patient cannot utilize the readily available over-the-counter version of this medication without benefit. As such, the request for capsaicin 0.075% Cream #2 (Rx 05/05/14) cannot be recommended as medically necessary.

Ketamine 5% Cream (Rx 05/05/14): Upheld

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

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

Decision rationale: As noted on page 111 of the Chronic Pain Medical Treatment Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Further, California Medical Treatment Utilization Schedule, Food and Drug Administration and Official Disability Guidelines require that all components of a compounded topical medication be approved for transdermal use. Ketamine has not been approved for transdermal use. Therefore Ketamine 5% Cream (Rx 05/05/14) cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.