

Case Number:	CM15-0005855		
Date Assigned:	02/09/2015	Date of Injury:	04/09/2011
Decision Date:	04/03/2015	UR Denial Date:	12/26/2014
Priority:	Standard	Application Received:	01/12/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California, Washington

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 48-year-old female who reported an injury on 04/09/2011. The mechanism of injury was not provided. The documentation indicated the injured worker's diagnosis was reflex sympathetic dystrophy. Prior therapies included physical therapy, massage, chiropractor care, acupuncture, and NSAIDs. The omeprazole was noted to be started since 2012, Zoloft, gabapentin, Norco, and Flexeril since 2013, Lyrica since 04/2014, and Owen's Pain Cream since 10/13/2014. The documentation indicated the injured worker had been certified for 3 stellate ganglion blocks from 02/09/2012 through 06/28/2012. There was a lack of documentation of objective functional improvement. Prior therapies additionally included ketamine infusions. There was a request for authorization submitted for review dated 01/28/2016. The documentation of 01/26/2015, revealed the injured worker followed up status post a series of 3 ganglion blocks, the last of which was noted to be performed on 01/05/2015, which reported approximately 10% pain relief. The injection that was her most successful was a 70% reduction for pain for approximately 3 weeks. The physical examination revealed allodynia in the right upper extremity. The injured worker has severe pain in the right wrist, elbow, and shoulder to light touch. There was pain and tenderness in the right shoulder and neck. There were a lot of muscle spasms in the thoracic paraspinal region, T4-T8, with extreme pain on palpation. Radicular pain was present on the cervical spine. The injured worker had a positive Spurling's test. The injured worker had facet tenderness that was present in the cervical spine. The axial loading of the cervical spine worsened the pain. Neck range of motion was limited. Diagnoses included reflex sympathetic dystrophy of the upper limb and cervicalgia. The

treatment plan included medications of omeprazole 20 mg, Zoloft 50 mg, gabapentin 300 mg, Norco 10/325 mg, Flexeril 10 mg, Lyrica 150 mg, and Owen's Pain Cream with 15% ketamine.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 referral for Ketamine infusions: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Introduction, Ketamine Page(s): 1, 56.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines recommend upon ruling out a potentially serious condition, conservative management is provided. If the complaint persists, the physician needs to reconsider the diagnosis and decide whether a specialist evaluation is necessary. Additionally, the California Medical Treatment Utilization Schedule Guidelines do not recommend ketamine for the treatment of chronic pain. There was a lack of documentation indicating a necessity for both a topical and intravenous form of ketamine. The request as submitted failed to indicate the dosage, and quantity of ketamine and number of infusions. There was a lack of documentation of objective functional benefit that was received from prior ketamine injections and an objective relief in pain to support the necessity for a referral and treatment with injections. The clinical documentation submitted for review failed to provide documentation of exceptional factors to warrant non-adherence to guideline recommendations. Given the above, the request for 1 referral for ketamine and fusion is not medically necessary.

3 Stellate ganglion blocks under fluoroscopic guidance: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Regional sympathetic blocks (stellate ganglion block, thoracic sympathetic block, & lumbar sympathetic block) Page(s): 103.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines recommend that sympathetic blocks are generally limited to diagnosis and therapy for CRPS. Stellate ganglion block (SGB) (Cervicothoracic sympathetic block): There is limited evidence to support this procedure, with most studies reported being case studies. The clinical documentation submitted for review failed to indicate the injured worker had exceptional pain relief and objective benefit from prior injections, as the most recent injection was noted to provide 10% relief and the 2nd injection gave 70% relief for 3 weeks. The specific date for the requested service was not provided. Given the above, and the lack of documentation of

exceptional factors, the request for 3 stellate ganglion blocks under fluoroscopic guidance is not medically necessary.

1 prescription Omeprazole 20mg: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation University of Michigan Health System. Gastroesophageal reflux disease (GERD). Ann Arbor (MI): University of Michigan Health System; 2012 May. 12 p. [11 references].

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 69.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor. The clinical documentation submitted for review failed to indicate the efficacy for the requested medication. The request as submitted failed to indicate the frequency and the quantity of medication being requested. Given the above, the request for 1 prescription of omeprazole 20 mg is not medically necessary.

1 prescription Zoloft 50mg: 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), Mental Illness & Stress.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines antidepressants Page(s): 13.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines recommend antidepressants as a first line medication for treatment of neuropathic pain and they are recommended especially if pain is accompanied by insomnia, anxiety, or depression. There should be documentation of an objective decrease in pain and objective functional improvement to include an assessment in the changes in the use of other analgesic medications, sleep quality and duration and psychological assessments. The clinical documentation submitted for review indicated the injured worker had utilized the medication for an extended duration of time. There was a lack of documentation of an objective decrease in pain and increased objective functional improvement, as well as an assessment in the changes of the use of other analgesic medications, including sleep quality, duration, and psychological assessments. The request as submitted failed to indicate the frequency and the quantity of the medication being requested. Given the above, the request for 1 prescription of Zoloft, 50 mg, is not medically necessary.

1 prescription Gabapentin 300mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepileptic Drugs Page(s): 16.

Decision rationale: The California MTUS guidelines recommend antiepilepsy medications as a first line medication for treatment of neuropathic pain. There should be documentation of an objective decrease in pain of at least 30 % - 50% and objective functional improvement. The clinical documentation submitted for review failed to provide an objective decrease in pain of at least 30% to 50% and an increase in objective functional improvement. Additionally, this medication was being concurrently reviewed with a second medication in this classification. There was a lack of documentation indicating a necessity for 2 medications in the same classification. The request as submitted failed to indicate the frequency for the requested medication. The request additionally failed to indicate the quantity of medications being requested. Given the above, the request for 1 prescription of gabapentin 300 mg is not medically necessary.

1 prescription Norco 10/325mg: 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, ongoing management Page(s): 60, 78.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend opiates for the treatment of chronic pain. There should be documentation of objective functional improvement, an objective decrease in pain, and documentation the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review failed to provide documentation of objective functional improvement, an objective decrease in pain, and documentation the injured worker is being monitored for aberrant drug behavior and side effects. The request as submitted failed to indicate the frequency for the requested medication, as well as the quantity being requested. Given the above, the request for 1 prescription of Norco 10/325 mg is not medically necessary.

1 prescription Flexeril 10mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines recommend muscle relaxants as a second line option for the short term treatment of acute low

back pain and their use is recommended for less than 3 weeks. There should be documentation of objective functional improvement. The clinical documentation submitted for review indicated the injured worker had utilized the medication for an extended duration of time. There was a lack of documentation of objective functional improvement. There was a lack of documentation of exceptional factors to warrant non-adherent to guideline recommendations. The request as submitted failed to indicate the frequency and the quantity of the medication being requested. Given the above, the request for 1 prescription of Flexeril 10 mg is not medically necessary.

1 prescription Lyrica 150mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepileptic Drugs Page(s): 16.

Decision rationale: The California MTUS guidelines recommend antiepilepsy medications as a first line medication for treatment of neuropathic pain. There should be documentation of an objective decrease in pain of at least 30 % - 50% and objective functional improvement. The clinical documentation submitted for review failed to provide an objective decrease in pain of at least 30% to 50% and an increase in objective functional improvement. Additionally, this medication was being concurrently reviewed with a second medication in this classification. There was a lack of documentation indicating a necessity for 2 medications in the same classification. The request as submitted failed to indicate the frequency for the requested medication. The request additionally failed to indicate the quantity of medications being requested. Given the above, the request for 1 prescription of Lyrica 150 mg is not medically necessary.

1 prescription Owen's Pain cream w/ 15% Ketamine: 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): 113.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines indicates that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety...topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The guidelines indicate that topical Ketamine is under study and is only recommended for treatment of neuropathic pain in refractory cases in which all primary and secondary treatment has been exhausted. The clinical documentation submitted for review failed to provide a necessity for both a topical and intravenous form of ketamine. There was a lack of documentation indicating

all primary and secondary treatments had been exhausted. The request as submitted failed to indicate the frequency and the quantity of medication being requested. The efficacy was not provided. Given the above, the request for 1 prescription of Owen's Pain Cream, with 5% ketamine, is not medically necessary.