

Case Number:	CM15-0009485		
Date Assigned:	01/27/2015	Date of Injury:	07/10/1989
Decision Date:	03/24/2015	UR Denial Date:	01/07/2015
Priority:	Standard	Application Received:	01/16/2015

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

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 62-year-old female who reported an injury on 07/10/1989. The mechanism of injury was lifting. She was diagnosed with lumbar disc displacement without myelopathy. Past treatments were noted to include a TENS unit, chiropractic therapy, massage therapy, acupuncture therapy, epidural injections, spinal cord stimulator, and medications. On 12/03/2014, the injured worker reported back pain. Upon physical examination, it was noted the injured worker had no abnormalities observed in regard to her gait. She had normal muscle tone in all 4 extremities. Her current medications were noted to include Norco 5/325 mg every 12 hours, ketamine 5% cream apply to affected area 3 times a day, and methadone HCl 10 mg 3 times a day. The treatment plan included medications and a request for cognitive behavioral therapy. On 01/13/2015, a letter of appeal was received. It was noted that the injured worker was using methadone for pain, and small amount of Norco for breakthrough pain. The injured worker had reported using Norco and methadone helped reduce her pain and improve her overall function. She was able to continue her home exercises with the help of medications. Without these medications, she would not be able to tolerate her pain. The treating physician indicated her latest UDS conducted on 09/26/2014 was positive for opioids. In regard to the ketamine cream, it was noted the injured worker reported numbness which is indicated for neuropathic pain for the use of ketamine. The treating physician indicated the injured worker has previously tried other medications including OxyContin, MS-Contin, Vicodin, buprenorphine sublingual troches, and Celebrex. Additionally, the treating physician indicated the injured worker had diarrhea with NSAIDs, and thus would be appropriate to minimize the use of NSAIDs in the

injured worker. The treating physician indicated given the functional benefits, her inability to tolerate NSAIDs and other oral medications, and her poor response to conservative treatments, the injured worker is a refractory case in which the use of ketamine cream is appropriate. The request for authorization was submitted on 12/18/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Norco 5/325mg, #30, DOS 11/5/2014: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for use Page(s): 78.

Decision rationale: The request for Retrospective Norco 5/325mg, #30, DOS 11/5/2014 is not medically necessary. The California MTUS Guidelines state that ongoing management of opioid use should include ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The clinical documentation submitted for review does indicate that the patient reported pain relief and increased function; however, there was no evidence of quantifiable pain relief provided. In the absence of this documentation, the request is not supported by the guidelines. Additionally, the request as submitted does not provide a frequency for the medication. As such, the request for Retrospective Norco 5/325mg, #30, DOS 11/5/2014 is not medically necessary.

Retrospective Methadone 10mg, #135, DOS 11/5/2014: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, specific drug list.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for use Page(s): 78.

Decision rationale: The request for Retrospective Methadone 10mg, #135, DOS 11/5/2014 is not medically necessary. The California MTUS Guidelines state that ongoing management of opioid use should include ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The clinical documentation submitted for review does indicate that the patient reported pain relief and increased function; however, there was no evidence of quantifiable pain relief provided. In the absence of this documentation, the request is not supported by the guidelines. Additionally, the request as submitted does not provide a frequency for the medication. As such, the request for Retrospective Methadone 10mg, #135, DOS 11/5/2014 is not medically necessary.

Ketamine 5% cream 60gr refills: 3: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics and Non-Steroidal Antiinflammatory agents (NSAI).

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

Decision rationale: The request for Ketamine 5% cream 60gr refills: 3 is not medically necessary. The California MTUS Guidelines note topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. The guidelines note ketamine 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 does not provide evidence that the patient has tried antidepressants or anticonvulsants. Additionally, there is no evidence of a quantifiable pain relief with use of the medication. Furthermore, the request as submitted does not provide a frequency for use. In the absence of this documentation, the request is not supported by the guidelines. As such, the request is not medically necessary.