

Case Number:	CM15-0134501		
Date Assigned:	07/22/2015	Date of Injury:	11/09/1995
Decision Date:	08/25/2015	UR Denial Date:	06/24/2015
Priority:	Standard	Application Received:	07/10/2015

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: Maryland, Texas, Virginia

Certification(s)/Specialty: Internal Medicine, Allergy and Immunology, Rheumatology

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 male who sustained an industrial injury on November 9, 1995. He has reported low back pain and has been diagnosed with syndrome post laminectomy lumbar and secondary revision in 2002 and lumbar disc displacement without myelopathy. Treatment has included medications, therapy, surgery, injections, acupuncture, aqua therapy, home exercises, and massage therapy. Lumbar extension was measured to be 10 degrees, lumbar flexion at 50 degrees, left lateral bending was at 10 degrees, and right lateral bending was at 10 degrees. Sensation was decreased in the dermatomes left, right L4, right L5. Straight leg raise was positive on the left and right. Spasm and guarding was noted about the lumbar spine. MRI dated June 19, 2008 revealed degenerative change and spondylosis of the lumbar spine, postoperative imaging artifact in the lower lumbar spine, L4-5 mild bilateral foraminal narrowing, and L5-S1 broad based disc protrusion with effacement of the anterior epidural space and mild abutement of the anterior thecal sac. There is obscuration of the foramina; however, there is probably moderate right and mild left foraminal narrowing. The treatment request included Ketamine and baclofen.

IMR ISSUES, DECISIONS AND RATIONALES

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

Baclofen 10mg 3 times a day, #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity Drugs - Baclofen (Lioresal, generic available) Page(s): 64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-64.

Decision rationale: Baclofen is classified as a muscle relaxant. MTUS states "Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP . . . Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement." Additionally, MTUS states "Baclofen (Lioresal, generic available): The mechanism of action is blockade of the pre- and post-synaptic GABAB receptors. It is recommended orally for the treatment of spasticity and muscle spasm related to multiple sclerosis and spinal cord injuries. Baclofen has been noted to have benefits for treating lancinating, paroxysmal neuropathic pain (trigeminal neuralgia, non-FDA approved). (ICSI, 2007)" The treating physician has not provided documentation of muscle spasms related to multiple sclerosis or spinal cord injuries. Additionally, the treating physician has not provided documentation of trials and failures of first line therapies. The patient has been on this medication on a long-term basis which is not recommended. As such, the request for Baclofen 10mg three times a day #90 is not medically necessary.

Ketamine 5% cream 2 times per day, 60gm #2: 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): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Compound creams.

Decision rationale: MTUS and ODG recommends usage of topical analgesics as an option, but also further details "primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed." The medical documents do not indicate failure of antidepressants or anticonvulsants. MTUS states, "There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." **KETAMINE (LAST RESORT TOPICAL):** MTUS states regarding topical Ketamine, "Under study: Only recommended for treatment of neuropathic pain in refractory cases in which all primary and secondary treatment has been exhausted." Medical records do not indicate that all primary and secondary treatment options have been exhausted. As such, the request for Ketamine 5% cream 2 times per day, 60gm #2 is not medically necessary.