

Case Number:	CM15-0145469		
Date Assigned:	08/06/2015	Date of Injury:	04/21/2008
Decision Date:	09/09/2015	UR Denial Date:	07/23/2015
Priority:	Standard	Application Received:	07/27/2015

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, North Carolina
 Certification(s)/Specialty: Family Practice

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 41-year-old male, who sustained an industrial injury on 4-21-08. He reported injury to his back, hip and left leg due to a slip and fall accident. The injured worker was diagnosed as having lumbar disc displacement without myelopathy, lumbar strain and headaches. Treatment to date has included a lumbar MRI on 3-2-15 showing L5-S1 foraminal stenosis. Current medications include Capsaicin cream, Gabapentin, Hydrocodone, Norflex and Ketamine cream since at least 1-14-15. As of the PR2 dated 7-16-15, the injured worker reports chronic lower back pain that radiates into his left lower extremity. He reports 40-50% pain relief with Norco and Ketamine cream. The treating physician noted that the injured worker was near ideal body weight, lumbar spasms and lumbar guarding. The treating physician requested physical therapy 2 x weekly for 3 weeks, a supervised weight loss program and Ketamine 5% cream 60gm #1 tube.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 2 times a week for 3 weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99.

Decision rationale: CA MTUS Guidelines state that patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. In this case, the documentation indicates chronic complaints of low back pain and bilateral hip pain. The request is for the diagnosis of iliopsoas tendinitis, however no objective findings regarding this anatomical region are found. Only muscular spasm is noted in the lumbar region on physical exam. Therefore, physical therapy is not medically necessary or appropriate in this case.

Supervised weight loss program: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 1 Prevention Page(s): 11.

Decision rationale: ACOEM Guidelines are utilized in this case. The medical necessity for a weight loss program is compared to evidence-based criteria for medical necessity. In this case, the patient weighs 425 lbs and is 7 feet tall. It has been recommended that he lose 100 lbs prior to spinal surgery. The documentation in the records submitted do not describe a failure of traditional dietary modifications and exercise as failing to facilitate weight loss. Therefore, the request for a formal weight loss program is not medically necessary or appropriate.

Ketamine 5% cream 60gm, SIG; apply to affected area 3 times daily #1: Upheld

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

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

Decision rationale: Topical analgesics are largely experimental in use with few randomized controlled trials to determine safety and efficacy. Ketamine is a NMSA receptor antagonist. It is only recommended topically for treatment of neuropathic pain in refractory cases in which primary and secondary treatments have failed. In this case, the patient is on Gabapentin and there is no evidence of failure to support topical Ketamine cream. Therefore, the request for Ketamine cream is not medically necessary or appropriate.