

Case Number:	CM15-0147444		
Date Assigned:	08/10/2015	Date of Injury:	04/06/2010
Decision Date:	09/21/2015	UR Denial Date:	07/23/2015
Priority:	Standard	Application Received:	07/29/2015

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

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 56 year old male, who sustained an industrial injury on 4-06-2010. He reported repetitive strain injury while working as a gas services representative. The injured worker was diagnosed as having cervical spinal stenosis, cervical spondylosis without myelopathy, lumbosacral spondylosis, and other pain disorders related to psychological factors. Treatment to date has included diagnostics, massage therapy, H wave, and medications. Currently, the injured worker reported no acute changes to his pain condition. He reported gradual worsening of pain since massage therapy. He reported significant benefit, noting that pain was 2 out of 10 from 8 out of 10. He reported better range of motion and less muscle tension. He was able to continue working and tolerate this generally well. Medications helped with pain and function and he was utilizing them intermittently. He denied side effects with medication use. Exam of the cervical spine noted tenderness to palpation along the cervical paraspinous muscles, left greater than right, with muscle tension extending into the bilateral upper trapezius muscles, and mildly decreased range of motion. He denied gastrointestinal symptoms. Current medications included Naproxen, Pantoprazole, Diclofenac cream, and Ketamine cream. The use of these medications was noted for at least 6 months. His work status was permanent and stationary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Naproxen Sodium (Anaprox) 550mg quantity 90: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non Steroidal Anti Inflammatory Drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory medications Page(s): 22.

Decision rationale: The patient was injured on 04/06/10 and presents with chronic low back pain and neck pain. The request is for NAPROXEN SODIUM (ANAPROX) 550 MG QUANTITY 90. The utilization review determination rationale is that "guides recommend it use of the lowest dose for the shortest period in patient with moderate to severe pain. It is noted that the patient states that it is only used intermittently and pain is now 2/10. Has returned to work and reports lower pain levels. Thus, this request is modified to #60." The RFA provided is dated 07/17/15 and the patient is working full time. The patient has been taking this medication as early as 11/13/14. MTUS Guidelines, Anti-inflammatory medications, page 22 states, "Anti-inflammatories are the traditional first line of treatment to reduce pain, so activity and functional restoration can resume, but long-term use may not be warranted." The patient has spasm / guarding along the lumbar spine, tenderness over the cervical paraspinous and trapezius on the right, and a decreased cervical spine range of motion. He is diagnosed with cervical spinal stenosis, cervical spondylosis without myelopathy, lumbosacral spondylosis, and other pain disorders related to psychological factors. The 12/15/14 report states that the patient rates his back pain as a 5/10, his neck pain to be an 8/10, and his shoulder pain to be a 3-4/10. The 07/16/15 report indicates that the patient "received significant benefit with pain that was reduced from 8/10 down to 2/10. Patient states that he is able to work better with less pain and exercise better with less pain. Patient states that he is able to continue working and is able to tolerate this generally well. Medications also help with pain and function but he is utilizing them intermittently. He denies any side effects with the medication." For medication use in chronic pain, MTUS page 60 requires documentation of pain assessment and function as related to the medication use. In this case, the treater benefits from Naproxen and is currently working. Therefore, the requested Naproxen IS medically necessary.

Diclofenac Sodium Cream 1.5% quantity 60gm: 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: The patient was injured on 04/06/10 and presents with chronic low back pain and neck pain. The request is for DICLOFENAC SODIUM CREAM 1.5% QUANTITY 60 GM. The RFA provided is dated 07/17/15 and the patient is working full time. The patient has been using this topical as early as 11/13/14. MTUS Guidelines, Topical Analgesics, page 111 states: "Topical Analgesics: Recommended as an option as indicated below. Non-steroidal anti-inflammatory agents (NSAIDs): The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. Voltaren Gel 1% (Diclofenac): Indicated for relief of osteoarthritis pain in joints that lend

themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder." MTUS Chronic Pain Medical Treatment Guidelines, page 9 under Pain Outcomes and Endpoints states: "All therapies are focused on the goal of functional restoration rather than merely the elimination of pain and assessment of treatment efficacy is accomplished by reporting functional improvement." The patient has spasm/guarding along the lumbar spine, tenderness over the cervical paraspinous and trapezius on the right, and a decreased cervical spine range of motion. He is diagnosed with cervical spinal stenosis, cervical spondylosis without myelopathy, lumbosacral spondylosis, and other pain disorders related to psychological factors. In this case, the patient presents with lumbar/cervical spine pain and MTUS guidelines state that "there is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip, or shoulder." Due to lack of support from MTUS guidelines, the requested Diclofenac Sodium IS NOT medically necessary.

Ketamine Cream 5% quantity 60 gm: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Compounded Medications.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Ketamine Page(s): 111, 56.

Decision rationale: The patient was injured on 04/06/10 and presents with chronic low back pain and neck pain. The request is for KETAMINE CREAM 5% QUANTITY 60 GM. The RFA provided is dated 07/17/15 and the patient is working full time. The patient has been using this topical as early as 11/13/14. MTUS Guidelines, Topical Analgesics, page 111 states that it is largely experimental in use with few randomized controlled trials to determine efficacy or safety. It is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. MTUS further states, "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." MTUS page 111 states "Non FDA-approved agents: Ketoprofen: This agent is not currently FDA approved for a topical application. It has an extremely high incidence of photocontact dermatitis." MTUS Guidelines, Ketamine, page 56 states, "Not recommended. There is insufficient evidence to support the use of Ketamine for the treatment of chronic pain." MTUS page 113 also has the following regarding Ketamine, "Under study: Only recommended for treatment of neuropathic pain in refractory cases in which all primary and secondary treatment have been exhausted. Topical Ketamine has only been studied for use in non-controlled studies for CRPS 1 and post-herpetic neuralgia, and both have shown encouraging results." The patient has spasm/guarding along the lumbar spine, tenderness over the cervical paraspinous and trapezius on the right, and a decreased cervical spine range of motion. He is diagnosed with cervical spinal stenosis, cervical spondylosis without myelopathy, lumbosacral spondylosis, and other pain disorders related to psychological factors. Regarding Ketamine, the patient has not been diagnosed with CRPS or post-herpetic neuralgia, and Ketamine has not been shown in any studies to provide functional improvement for other neuropathic pain. Therefore, the requested Ketamine Cream IS NOT medically necessary.