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| Case Number: | CM15-0184050 | | |
| Date Assigned: | 09/25/2015 | Date of Injury: | 04/06/2010 |
| Decision Date: | 11/06/2015 | UR Denial Date: | 08/31/2015 |
| Priority: | Standard | Application Received: | 09/18/2015 |

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: New Jersey

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 56-year-old male, with a reported date of injury of 04-06-2010. The diagnoses include cervical spine stenosis, cervical spondylosis without myelopathy, lumbosacral spondylosis, chronic pain, and pain psychogenic. Treatments and evaluation to date have included Naproxen (Anaprox), Pantoprazole (Protonix), Diclofenac sodium (since at least 02-2015), Ketamine cream (since at least 02-2015), massage therapy with significant benefit, and H-wave therapy. The diagnostic studies to date have not been included in the medical records. The visit note dated 07-16-2015 indicates that the injured worker presented with chronic low back pain and neck pain. It was noted that the injured worker did not feel that his pain had gradually worsened since his massage therapy. He stated that he received significant benefit with pain which was reduced from 8 out of 10 down to 2 out of 10. The injured worker also stated that he had better range of motion and much less muscle tension; he was able to work better with less pain and exercise better with less pain; and that he was able to continue working and was able to tolerate this generally well. There were no side effects with the medication according to the injured worker. The objective findings include tenderness to palpation along the cervical paraspinal muscles, left-sided greater than right with muscle tension extending into the bilateral upper trapezius muscles, decreased cervical spine range of motion by 20% with flexion, and full range of motion with extension and 10% with rotation to the left. It was noted that an MRI on 09-25-2012 showed chronic tear of the superior labrum extending into the anterosuperior to posterosuperior, degeneration of the anteroinferior and posterosuperior labrum; mild to moderate rotator cuff tendinosis; no rotator cuff tear; tendinosis of the intra-articular long head biceps

tendon; mild acromioclavicular joint arthrosis; and lateral down sloping acromion narrowing of the lateral supraspinatus outlet. The treatment plan included a refill of medications. It was indicated that the injured worker was permanent and stationary with permanent disability. The injured worker was to return to full duty without restrictions. The request for authorization was dated 07-17-2015. The treating physician requested Diclofenac Sodium Cream 1.5% #60 grams (date of service: 07-16-2015) and Ketamine Cream 5% #60 grams (date of service: 07-16-2015). On 08-31-2015, Utilization Review (UR) non-certified the request for Diclofenac Sodium Cream 1.5% #60 grams (date of service: 07-16-2015) and Ketamine Cream 5% #60 grams (date of service: 07-16-2015).

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Diclofenac Sodium Cream 1.5%gm (DOS: 7/16/2015): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation <http://www.odg-twc.com/odgtwc/pain.htm#DiclofenacSodiumListing>.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: The MTUS Chronic Pain Guidelines state that topical analgesics are generally considered experimental as they have few controlled trials to determine efficacy and safety currently. Topical NSAIDs, specifically, have some data to suggest it is helpful for osteoarthritis and tendinitis for at least short periods of time, but there are no long-term studies to help us know if they are appropriate for treating chronic musculoskeletal pain. Topical NSAIDs have not been evaluated for the treatment of the spine, hip, or shoulder. Although some topical analgesics may be appropriate for trial as a secondary agent for neuropathic pain after trials of oral therapies have been exhausted, topical NSAIDs are not recommended for neuropathic pain. The only FDA-approved topical NSAID currently is Voltaren gel (diclofenac). Ketoprofen is not currently one of the topical NSAIDs available that is FDA approved, and it has a high incidence of photo contact dermatitis. All topical NSAID preparations can lead to blood concentrations and systemic effect comparable to those from oral forms and caution should be used for patients at risk, including those with renal failure and hypertension. In the case of this worker, the topical diclofenac was used to help treat spinal pain (back, neck) which is not approved for this type of medication. Also, if the intention was to reduce the use of oral NSAIDs, then a prescription for less oral NSAIDs would be most appropriate, which was not the case for this worker, and two NSAID prescriptions is not medically necessary.

Retrospective Ketamine Cream 5% #60 (DOS: 7/16/2015): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Ketamine.

Decision rationale: The MTUS Chronic Pain Guidelines state that ketamine is generally not recommended as there is insufficient evidence to support its use for the treatment of chronic pain and has been associated with frequent side effects. Topical ketamine is only recommended for treatment of neuropathic pain in refractory cases in which all primary and secondary treatment has been exhausted. In the case of this worker, although there was report of neuropathic pain, there was no record which suggested all other medications for neuropathic pain (first-line medications) had been used prior to considering ketamine. Therefore, the request for topical ketamine will be considered medically unnecessary at this time.