MAXIMUS Federal Services

Case Number:	CM15-0191862		
Date Assigned:	10/06/2015	Date of Injury:	03/25/2005
Decision Date:	11/18/2015	UR Denial Date:	09/23/2015
Priority:	Standard	Application Received:	09/29/2015

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, Hawaii
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 57 year old female, who sustained an industrial-work injury on 3-25-05. A review of the medical records indicates that the injured worker is undergoing treatment for lumbar degenerative disc disease (DDD), status post bilateral hip replacement; Reflex sympathetic dystrophy syndrome left upper extremity, lumbar spinal stenosis and psychogenic pain. Medical records dated (5-20-15 to 9-9-15) indicate that the injured worker complains of continued low back pain with radiation of pain into both legs. She also has pain in both hips and difficulty with ambulation. She wears a right hip brace to help prevent rotation of the right hip. The pain is rated 8 out of 10 on the pain scale and constant. The medications relieve the pain and decrease it to 6 out of 10 on the pain scale. This has been unchanged from previous visits. The injured worker reports chronic vomiting and diarrhea and she also has gastroesophogeal reflux. Per the treating physician report dated 9-9-15 work status is permanent and stationary. The physical exam dated from (8-12-15 to 9-9-15) reveals that he injured worker has antalgic gait, uses a walker for assistance with ambulation, and wears a brace on her right hip and wears a back brace. Treatment to date has included pain medication including Morphine sulfate, Opana IR, Seroquel, and topical analgesic compounds since at least 5-20-15, activity modifications, bracing, diagnostics, urine drug screen and other modalities. The treating physician indicates that the urine drug test result dated 3-20-15 was consistent with the medication prescribed. The request for authorization date was 9-17-15 and requested services included Ketamine-Veraspro topical and Doxepin-Veraspro topical. The original Utilization review dated 9-23-15 non-certified the request for Ketamine-Veraspro topical and Doxepin-Veraspro topical.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ketamine/Veraspro topical: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), update.

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

Decision rationale: The patient presents with diagnoses that include lumbar degenerative disc disease, stenosis spinal lumbar, and status post bilateral hip replacement, RSI left upper extremity, depression and anxiety. The patient recently complained of back and bilateral hip pain. She continues to have low back pain with radiation into both legs. The current request is for Ketamine/Veraspro topical. The treating physician states in the treating report dated 9/9/15 (89B), Ketamine 5% cream 60gr SIG. Apply to affected area three times a day numbing & pain cream QTY: 2.00 REF: 3. MTUS Guidelines consider topical analgesics largely experimental in use and recommend their use for neuropathic pain when trials of anti-depressants and anti-convulsion have failed; applied locally to painful areas. MTUS also states "Ketamine: Under study: Only recommended for treatment of neuropathic pain in refractory cases in which all primary and secondary treatment has been exhausted." In this case, the treating physician documents in the treating report dated 9/9/15 (90B), that the patient "continues to have persistent back pain with radiation into the legs as well as pain in both hips." The clinical history also notes the patient has treated with the requested topical analgesic compound since at least 3/20/15 (19B). However, the medical necessity for the current requested treatment cannot be found because the current request is for an unknown count, quantity and/or duration of use. While the treating report did indeed specify the exact count, quantity and/or duration of use the IMR application failed to do so. Therefore, the current request, as documented in the IMR application, cannot be approved because an approval could be interpreted as an endless supply of the requested treatment. The current request is not medically necessary.

Doxepin/Veraspro topical: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Clin J Pain 2008 Jan; 24 (1): 51-5. Topical amitriptyline versus lidocaine in the treatment of neuropathic pain. Ho KY, Huh BK, WHite WD, Yeh CC, Miller EJ.

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

Decision rationale: The patient presents with diagnosis that includes lumbar degenerative disc disease, stenosis spinal lumbar, and status post bilateral hip replacement, RSI left upper extremity, depression and anxiety. The patient recently complained of back and bilateral hip

pain. She continues to have low back pain with radiation into both legs. The current request is for Doxepin/Veraspro topical. The treating physician states in the treating report dated 9/9/15 (89B), "Doexpin 3.3% Gel 60gr SIG. Apply to affected area three times a day QTY: 1.00 REF: 3." MTUS Guidelines on topical analgesics state 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." According to www.medicinenet.com "Doxepin is used to relieve troublesome itching from certain skin conditions (e.g., atopic dermatitis, eczema, neurodermatitis)." It further states that it should be used only for a short time (no more than 8 days). Doxepin is a tricyclic antidepressant. In this case, there is no indication that this patient is experiencing atopic dermatitis, eczema, neurodermatitis, etc. Furthermore, the clinical history also notes the patient has been treated with the requested topical analgesic compound since at least 3/20/15 (19B). However, the medical necessity for the current requested treatment cannot be found because the current request is for an unknown count, quantity and/or duration of use. While the treating report did indeed specify the exact count, quantity and/or duration of use the IRM application failed to do so. Therefore, the current request, as documented in the IMR application, could not be approved because it is an open-ended request. The current request is not medically necessary.