

<b>Case Number:</b>	CM15-0221460		
<b>Date Assigned:</b>	11/16/2015	<b>Date of Injury:</b>	08/10/2011
<b>Decision Date:</b>	12/31/2015	<b>UR Denial Date:</b>	10/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/09/2015

### 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: Texas, California

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 37 year old male injured worker suffered an industrial injury on 8-10-2011. The diagnoses included left Reflex Sympathetic Dystrophy, lumbar sprain-strain, lumbar facet arthropathy, depression and anxiety, insomnia and history of fibromyalgia. On 8-18-2015, the provider reported 8 out of 10 pain with tingling and numbness that was constant going up into the back. He cannot have any material touch his leg because of pain with stiffness of the back, swelling in the left foot along with color changes and clawing of the toes. Medications currently in use were Gabapentin 1200mg in the morning and evening with 600mg in the daytime, Baclofen, Ibuprofen and Percocet. The other medication list includes Cymbalta, Naproxen, Flexeril and Tramadol. He noted Percocet was making him itch so the provider noted he would switch it back to Norco as he was previously on it without side effects. He trialed physical therapy where desensitization and mirror therapy were attempted but this caused a flare of the pain. He had difficulty making meals, walking on flat ground, going up and down stairs, standing, light housework or running errands and also reported difficulty sleeping. He also reported severe headaches. On exam, the gait was altered with a cane in the left hand, avoiding contact with the floor. There was tenderness particularly in the left lumbar muscles. There was reduced painful lumbar range of motion. The lumbar facet stress test was positive. There was hyperesthesia and allodynia on gentle touch. He was able to map the area where the allodynia started and ended. The injured worker had been seeing a pain psychologist through the private insurance and the provider would like to have it through Worker's Compensation. The pain psychologist would work with him on pain coping skills, cognitive behavioral therapy, breathing exercises and also

address the insomnia. The recommended Ketamine or Lidocaine intravenous infusion therapy requested treatment did not include specific dosages and duration of therapy. Prior treatments included 27 lumbar sympathetic blocks. Utilization Review on 10-27-2015 determined non-certification for IV Lidocaine or Ketamine weekly drip (unspecified type-dose-duration) and Pain Psychology (unspecified treatment plan). The patient sustained the injury due to stepping off of a ladder. The patient has had history of accidental puncture of the GI system with lumbar sympathetic block procedure on 10/19/12. The patient has had history of severe depression. A recent detailed psychiatric examination was not specified in the records provided.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **IV Lidocaine or Ketamine weekly drip (unspecified type/dose/duration): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Lidoderm (lidocaine patch), NSAIDs (non-steroidal anti-inflammatory drugs).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter, Ketamine, Intravenous regional sympathetic blocks (for RSD/CRPS).

**Decision rationale:** IV Lidocaine or Ketamine weekly drip (unspecified type/dose/duration). As per the cited guideline "Ketamine: Not recommended. There is insufficient evidence to support the use of ketamine for the treatment of CRPS. Current studies are experimental and there is no consistent recommendation for protocols, including for infusion solutions (in terms of mg/kg/hr), duration of infusion time, when to repeat infusions, how many infusions to recommend, or what kind of outcome would indicate the protocol should be discontinued. The safety of long-term use of the drug has also not been established, with evidence of potential of neurotoxicity. Ketamine-induced liver toxicity is a major risk, occurring up to 50% of the time, and regular measures of liver function are therefore required during such treatments. (Noppers, 2011) Frequent use can cause long-term memory impairment and altered pre-frontal dopaminergic function. (Morgan, 2012) Ketamine is also known as a drug of abuse. Abuse of ketamine can cause cystitis and a contracted bladder, and secondary renal damage can occur in severe cases which might be irreversible, rendering patients dependent on dialysis. (Chu, 2008) (Morgan, 2012) There is no evidence of a cure of CRPS with subanesthetic infusions. The limited results of current research studies on this topic are inconsistent." Not recommended due to lack of evidence for use. There is no role for IV diagnostic blocks with phentolamine or IVRA with guanethidine. The cited guideline do not recommended IV Lidocaine or Ketamine drip and there is insufficient evidence to support the use of ketamine for the treatment of CRPS. In addition there is no consistent recommendation for protocols, including for infusion solutions (in terms of mg/kg/hr), duration of infusion time, when to repeat infusions, how many infusions to recommend, or what kind of outcome would indicate the protocol should be discontinued. A detailed rationale for the use of IV Lidocaine or Ketamine weekly drip (unspecified type/dose/duration) was not specified in the records specified. Evidence of diminished effectiveness of oral medications or intolerance to oral medications was not specified in the records provided. The exact dose and duration of the IV Lidocaine or Ketamine weekly drip was not specified in the records specified. The request for IV Lidocaine or Ketamine weekly drip (unspecified type/dose/duration) is not medically necessary.

**Pain Psychology (unspecified treatment plan):** Overturned

**Claims Administrator guideline:** Decision based on MTUS Stress-Related Conditions 2004.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, IME and consultations.

**Decision rationale:** Pain Psychology (unspecified treatment plan). Per the cited guidelines, "The occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise." The diagnoses included left Reflex Sympathetic Dystrophy, lumbar sprain-strain, lumbar facet arthropathy, depression and anxiety, insomnia and history of fibromyalgia. On 8-18-2015, the provider reported 8 out of 10 pain with tingling and numbness that was constant going up into the back. He cannot have any material touch his leg because of pain with stiffness of the back, swelling in the left foot along with color changes and clawing of the toes. He had difficulty making meals, walking on flat ground, going up and down stairs, standing, light housework or running errands and also reported difficulty sleeping. He also reported severe headaches. On exam, the gait was altered with a cane in the left hand, avoiding contact with the floor. There was tenderness particularly in the left lumbar muscles. There was reduced painful lumbar range of motion. The lumbar facet stress test was positive. There was hyperesthesia and allodynia on gentle touch. The patient has had a history of accidental puncture of the GI system with a lumbar sympathetic block procedure on 10/19/12. The patient has had a history of severe depression. Therefore, this is a complex case with psychosocial factors and abnormal objective exam findings present. The pain psychologist would work with him on pain coping skills, cognitive behavioral therapy, breathing exercises and also address the insomnia. The management of this case would be benefited by a referral to a Pain Psychologist. The request for referral to a Pain Psychologist is medically necessary and appropriate for this patient.