

<b>Case Number:</b>	CM14-0133411		
<b>Date Assigned:</b>	08/22/2014	<b>Date of Injury:</b>	06/06/2006
<b>Decision Date:</b>	10/08/2014	<b>UR Denial Date:</b>	08/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/20/2014

### 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. The expert reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This patient is a 71-year-old male who has submitted a claim for lumbar disc displacement without myelopathy, sciatica, sacrum disorder, and depression associated with an industrial injury date of 6/6/2006. Medical records from 2013 to 2014 were reviewed. Patient complained of low back pain radiating to the left lower extremity, associated with numbness and tingling sensation. He likewise reported subjective weakness of the left leg. Physical examination on of the lumbar spine showed tenderness and muscle spasms. Gait was antalgic. Straight leg raise test was positive on the left. Sensation was diminished at left L4 to S1 dermatomes. Urine drug screen result from 3/14/2014 was consistent with prescription medications. Appeal letter from 8/22/2014 cited that current treatment regimen provided overall symptom relief and functional improvement. He denied any adverse effects from medication use. Valium provided relief from severe muscle spasms. Patient likewise reported that previous use of ketamine provided symptom relief from neuropathic pain. Patient was started on fentanyl patch due to severe sedation experienced from previous use of methadone. Treatment to date has included lumbar epidural steroid injection, physical therapy, and medications such as Valium (since 2013), Fentanyl (since 2013), Norco (since January 2014), diclofenac, Norflex, and ketamine cream (since June 2014). Utilization review from 8/7/2014 denied the request for Retro Ketamine 5% Cream 60 GR. DOS 6/4/14 because it was only recommended for CRPS and postherpetic neuralgia; denied Retro Hydrocodone/APAP 10-325 MG. DOS 6/4/14 and Retro Fentanyl 50 MCG/HR. Patch DOS 6/4/14 because there was no evidence of functional improvement with medication use; and denied Retro Valium 10 MG. DOS 06/4/14 because long-term use was not recommended.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retro Ketamine 5% Cream 60 GR. DOS 6/4/14: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 113.

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

**Decision rationale:** As stated on pages 111-113 of the California MTUS Chronic Pain Medical Treatment Guidelines, topical analgesics are largely experimental in use with few randomized controlled trials to determine safety or efficacy. Ketamine is only recommended for treatment of neuropathic pain in refractory cases in which all primary and secondary treatment has been exhausted. In this case patient was re-prescribed ketamine cream since the June 2014. Topical analgesic was given as adjuvant therapy to oral medications. Appeal letter from 8/22/2014 stated that first line oral therapy resulted to gastrointestinal complications, prompting prescription of topical analgesic. Patient likewise reported that previous use of ketamine provided symptom relief from neuropathic pain. The medical necessity was established. However, the request as submitted failed to specify quantity dispensed. The request was incomplete; therefore, the request for Retro Ketamine 5% Cream 60 GR. DOS 6/4/14 was not medically necessary.

**Retro Hydrocodone/APAP 10-325 MG. DOS 6/4/14: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines When to Discontinue Opioids Page(s): 79.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

**Decision rationale:** As stated on page 78 of CA MTUS Chronic Pain Medical Treatment Guidelines, there are 4 A's for ongoing monitoring of opioid use: pain relief, side effects, physical and psychosocial functioning and the occurrence of any potentially aberrant drug-related behaviors. The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. In this case, patient has been on hydrocodone/apap since January 2014. Appeal letter from 8/22/2014 cited that current treatment regimen provided overall symptom relief and functional improvement. He denied any adverse effects from medication use. Urine drug screen result from 3/14/2014 was likewise consistent with prescription medications. Guideline criteria for continuing opioid management were met. However, the request as submitted failed to specify quantity dispensed. The request was incomplete; therefore, the request for Retro Hydrocodone/APAP 10-325 MG. DOS 6/4/14 was not medically necessary.

**Retro Valium 10 MG. DOS 06/4/14: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

**Decision rationale:** As stated on page 24 of CA MTUS Chronic Pain Medical Treatment Guidelines, benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. In this case, patient has been on Valium since 2013. Patient reported symptom relief from severe muscle spasm upon medication use, allowing him to perform activities of daily living. However, long-term use of benzodiazepine was not recommended. Moreover, the request as submitted failed to specify a quantity to be dispensed. Therefore, the request for Retro Valium 10 MG. DOS 06/4/14 was not medically necessary.

**Retro Fentanyl 50 MCG/HR. Patch DOS 6/4/14:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic; Opioids; Fentanyl (transdermal) Page(s): 44,78;93.

**Decision rationale:** Page 44 of CA MTUS Chronic Pain Medical Treatment Guidelines states that "Duragesic (fentanyl transdermal system) is not recommended as a first-line therapy. Furthermore, page 93 also states that Duragesic is indicated for management of persistent chronic pain, which is moderate to severe requiring continuous, around-the-clock opioid therapy that cannot be managed by other means (e.g., NSAIDS). , There are 4 A's for ongoing monitoring of opioid use: pain relief, side effects, physical and psychosocial functioning and the occurrence of any potentially aberrant drug-related behaviors. In this case, patient has been on fentanyl patch since 2013. He was started on fentanyl patch due to severe sedation experienced from previous use of methadone. Appeal letter from 8/22/2014 cited that current treatment regimen provided overall symptom relief and functional improvement. He denied any adverse effects from medication use. Urine drug screen result from 3/14/2014 was likewise consistent with prescription medications. Guideline criteria for continuing opioid management were met. However, the request as submitted failed to specify quantity dispensed. Therefore, the request for Retro Fentanyl 50 MCG/HR. Patch DOS 6/4/14 was not medically necessary.