

Case Number:	CM14-0161984		
Date Assigned:	10/07/2014	Date of Injury:	04/16/1996
Decision Date:	11/04/2014	UR Denial Date:	09/23/2014
Priority:	Standard	Application Received:	10/02/2014

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 Emergency Medicine and is licensed to practice in New York. 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:

The patient is a 47-year-old male who was injured on April 16, 1996. The patient continued to experience chronic low back pain. Physical examination was notable for normal muscle tone in all extremities, negative straight leg raise, intact sensations and normal motor strength. Diagnoses included lumbar disc displacement without myelopathy and lumbago. Treatment included medications, physical therapy, epidural steroid injections, and lumbar radiofrequency facet denervation. Requests for authorization for Fentanyl patch 75 mcg/hr #15, Lidoderm 5% patch #30 with 4 refills, and ketamine 5% cream 60 gr were submitted for consideration.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 prescription of Fentanyl 75mcg/hr patch #15: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 74-96.

Decision rationale: Fentanyl is an opioid analgesic with a potency eighty times that of morphine. Weaker opioids are less likely to produce adverse effects than stronger opioids such as fentanyl. It is indicated for management of persistent chronic pain, which is moderate to severe

requiring continuous, around-the-clock opioid therapy. The pain cannot be managed by other means. Transdermal should only be used in patients who are currently on opioid therapy for which tolerance has developed. In this case there is no documentation that the patient has developed tolerance to other opioid therapy. Medical necessity has not been established.

1 prescription of Lidoderm 5% patch #30 with 4 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 112. Decision based on Non-MTUS Citation Pain, Lidoderm

Decision rationale: Lidocaine is recommended for localized peripheral pain after the evidence of a trial for first-line therapy, such as an antidepressant or antiepileptic drug. It is only FDA approved for the treatment of post-herpetic neuralgia. The guidelines state that further research is needed to recommend this treatment for chronic neuropathic pain. Criteria for use of Lidoderm patches: a) Recommended for a trial if there is evidence of localized pain that is consistent with a neuropathic etiology.(b) There should be evidence of a trial of first-line neuropathy medications (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica).(c) This medication is not generally recommended for treatment of osteoarthritis or treatment of myofascial pain/trigger points.(d) An attempt to determine a neuropathic component of pain should be made if the plan is to apply this medication to areas of pain that are generally secondary to non-neuropathic mechanisms (such as the knee or isolated axial low back pain). One recognized method of testing is the use of the Neuropathic Pain Scale.(e) The area for treatment should be designated as well as number of planned patches and duration for use (number of hours per day).(f) A Trial of patch treatment is recommended for a short-term period (no more than four weeks).(g) It is generally recommended that no other medication changes be made during the trial period.(h) Outcomes should be reported at the end of the trial including improvements in pain and function, and decrease in the use of other medications. If improvements cannot be determined, the medication should be discontinued.(i) Continued outcomes should be intermittently measured and if improvement does not continue, lidocaine patches should be discontinued.In this case the documentation in the medical record does not support the presence of neuropathic pain. In addition, there is no documentation that the patient has failed treatment with first-line neuropathic medications. Criteria for the use of Lidoderm patches have not been met. The request is not medically necessary.

1 prescription of Ketamine 5% cream 60gr: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 56.

Decision rationale: Ketamine is not recommended. Ketamine is an anesthetic in animals and humans; it is also a drug of abuse in humans, but ketamine may offer a promising therapeutic option in the treatment of appropriately selected patients with intractable complex regional pain syndrome (CRPS). More study is needed to further establish the safety and efficacy of this drug. There is insufficient evidence to support the use of ketamine for the treatment of chronic pain. The request is not medically necessary.