

Case Number:	CM15-0061451		
Date Assigned:	04/07/2015	Date of Injury:	11/09/1995
Decision Date:	06/09/2015	UR Denial Date:	03/17/2015
Priority:	Standard	Application Received:	04/01/2015

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, Washington

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 54-year-old male, who sustained an industrial injury on November 9, 1995, incurring back injuries. The injured worker subsequently underwent a lumbar fusion. Conservative treatments include lumbar epidural steroid injection, and pain management. The diagnosis is degenerative lumbar spine disease with disc protrusions. The injured worker presented on 02/24/2015 for a follow-up evaluation with complaints of increasing pain in the low back. The injured worker was concerned about the hardware in the low back. It was also noted that the injured worker was pending authorization for a surgical consultation. Upon examination of the lumbar spine, there was 10 degrees extension, 50 degrees flexion, 10 degrees right and left lateral bending, decreased sensation in the bilateral L4 and L5 dermatomes, positive straight leg raise bilaterally, paravertebral muscle spasm, and guarding. The current medication regimen includes Viagra, Cymbalta, Fioricet, Ambien, baclofen, ketamine 5% cream, morphine sulfate, and lovastatin. Treatment recommendations at that time included a lumbar spine MRI and continuation of the current medication regimen. There was no Request for Authorization form submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ambien CR 12.5 mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation FDA.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Insomnia Treatment.

Decision rationale: The Official Disability Guidelines recommend insomnia treatment based on etiology. Ambien is indicated for the short-term treatment of insomnia with difficulty of sleep onset for 7 to 10 days. In this case, the injured worker does not maintain a diagnosis of insomnia disorder. In addition, the injured worker has continuously utilized the above medication since at least 10/2014. Guidelines do not support long-term use of hypnotic medication. There is also no frequency listed in the request. Given the above, the request is not medically necessary.

Floriset (Butalbital/APAP/Caffeine) #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-pain chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 23.

Decision rationale: California MTUS Guidelines do not recommend barbiturate containing analgesic agents for chronic pain. There is a risk of medication overuse as well as rebound headache. The injured worker has continuously utilized the above medication since at least 10/2014. There is no mention of functional improvement despite the ongoing use of this medication. There is also no frequency listed in the request. Given the above, the request is not medically necessary.

Ketamine 5% cream 60 grams: Upheld

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

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

Decision rationale: California MTUS Guidelines do not recommend ketamine. There is insufficient evidence to support the use of ketamine for the treatment of chronic pain. The current request for a compounded cream containing ketamine 5% would not be supported. There is also no frequency listed in the request. As such, the request is not medically necessary.

Baclofen 10 mg #90: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Baclofen 10 mg #90 pain chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

Decision rationale: California MTUS Guidelines state muscle relaxants are recommended as non-sedating second line options for short-term treatment of acute exacerbations. The injured worker has utilized the above medication since at least 10/2014. Despite the ongoing use of this medication, the physician noted palpable muscle spasm upon examination. There is no documentation of objective functional improvement. There is also no frequency listed in the request. As such, the request is not medically necessary.