
Notice of Independent Medical Review Determination

Dated: 10/22/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/22/2013
Date of Injury:	9/11/2003
IMR Application Received:	7/29/2013
MAXIMUS Case Number:	CM13-0004049

- 1) MAXIMUS Federal Services, Inc. has determined the request for 1 prescription of Ketamine 5% cream 60gr. #2 **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for 1 prescription of Hydrocodone/APAP (Norco) 10/325mg # 60 **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/29/2013 disputing the Utilization Review Denial dated 7/22/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/5/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the request for 1 prescription of Ketamine 5% cream 60gr. #2 **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for 1 prescription of Hydrocodone/APAP (Norco) 10/325mg # 60 **is not medically necessary and appropriate.**

Medical Qualifications of the Expert Reviewer:

The Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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 treatments and/or services at issue.

Case Summary:

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated July 22, 2013:

“The patient is a 51-year-old female with a date of injury of 9/11/2003. The provider has submitted authorization requests for 1 prescription of ketamine 5% cream 60gr #2 and 1 prescription of hydrocodone/APAP (Norco) 10/325mg #60. This is an appeal to review #I 044450. According to the submitted records, the patient is being treated for chronic intractable pain to multiple body parts second try to an industrial injury. The provider is requesting certification for ketamine 5% cream for a second time, as the first request was non-certified in review #1044450 on 7/2/2013. This non-certification was based on lack of guideline support for prolonged use and associated high rate of risk for abuse and adverse reaction. The provider submitted an appeal letter describing the medical necessity and response to prior use of the medication. The provider is appealing the prior determination at this time.”

Documents Reviewed for Determination:

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application for Independent Medical Review dated 7/29/2013
- Utilization Review Determination from Claims Administrator [REDACTED]
- Employee medical records from [REDACTED]
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request 1 prescription of Ketamine 5% cream 60gr. #2:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, page not cited, part of the MTUS. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the MTUS Chronic Pain Medical Treatment Guidelines, page 111, Topical Analgesics, relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee reported a work-related injury on 9/11/2003. The submitted and reviewed medical records indicate that the employee has been diagnosed with suspected cervical stenosis, right cervical radiculopathy, chronic low back pain, depression, status post tarsal tunnel surgical release, chronic bilateral plantar fasciitis status post surgical treatment, chronic pain syndrome, opioid tolerance, right trigger thumb and middle fingers, and bilateral lower extremity pain complaints. A clinical note, dated 7/22/2013, indicated that the employee expressed burning and swelling in the feet with significant relief of pain with the utilization of ketamine cream. A request was submitted for Ketamine 5% cream 60gr. #2 and one prescription of Hydrocodone/APAP (Norco) 10/325mg # 60.

MTUS Chronic Pain Medical Treatment Guidelines indicate that "Ketamine topical is under study and only recommended for treatment of neuropathic pain in refractory cases in which all primary and secondary treatment has been exhausted. Topical ketamine has only been studied for use in non-controlled studies for CRPS I and post-herpetic neuralgia and both have shown encouraging results." However, ketamine is currently not FDA approved for topical application. The request for Ketamine 5% cream 60gr. # 60, **is not medically necessary and appropriate.**

2) Regarding the request for 1 prescription of Hydrocodone/APAP (Norco) 10/325mg # 60:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, no page cited, a part of the MTUS. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the Chronic Pain Medical Treatment Guidelines, Opioids, criteria for use, On-Going Management, page 78 and Hydrocodone/Acetaminophen, page 91, part of the MTUS, relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee reported a work-related injury on 9/11/2003. The submitted and reviewed medical records indicate that the employee has been diagnosed with suspected cervical stenosis, right cervical radiculopathy, chronic low back pain, depression, status post tarsal tunnel surgical release, chronic bilateral plantar fasciitis status post surgical treatment, chronic pain syndrome, opioid tolerance,

right trigger thumb and middle fingers, and bilateral lower extremity pain complaints. A clinical note, dated 7/22/2013, indicated that the employee expressed burning and swelling in the feet with significant relief of pain with the utilization of ketamine cream. A request was submitted for Ketamine 5% cream 60gr. #2 and one prescription of Hydrocodone/APAP (Norco) 10/325mg # 60.

MTUS Chronic Pain Medical Treatment Guidelines indicate, “4 domains have been proposed as most relevant for ongoing monitoring of chronic pain employees on opioids: Pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. These domains have been summarized as the “4 A’s” (analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behavior). 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.” The current request previously received an adverse determination due to the employee’s current medication regimen far exceeds the recommended guideline for morphine equivalent dose of 120 per day. The records indicate the requested medication was modified for recommendations of weaning as the employee had recently begun utilizing morphine extended release. The request for 1 prescription of Hydrocodone/APAP (Norco) 10/325 mg #60 **is not medically necessary and appropriate.**

Effect of the Decision:

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely;

Richard C. Weiss, MD, MPH, MMM, PMP
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

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Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.