

Case Number:	CM13-0037034		
Date Assigned:	12/13/2013	Date of Injury:	10/30/2012
Decision Date:	02/06/2014	UR Denial Date:	10/18/2013
Priority:	Standard	Application Received:	10/22/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Internal Medicine and is licensed to practice in Maryland and the District of Columbia. 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 physician 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 claimant is a 50 year old male who sustained injuries in his neck and back during the course of his employment on 30 October 2012. The claimant complained of back pain that radiates into both of his legs. He also complained of right sided neck pain and numbness in his upper extremities. He had a history of cervical spine fusion at C5-4 and C6-C7 in 1999, left inguinal hernia repair, left ring finger fracture. He presented in 2012 with above complaint and was found to have severe acquired central canal stenosis of cervical spine had a cervical microdiscectomy with arthrodesis and fusion anterior and posterior from C3 to C6. A follow up MRI for persistent pain showed bilateral C4-C5 neural foraminal narrowing and right neuroforaminal stenosis at C2-3 and C3-4. EMG showed right L5 radiculopathy and bilateral C6 radiculopathies. Medications included Ibuprofen, Hydrocodone 10/325mg, Mirtazapine, Cymbalta, Cyclobenzaprine, Lidocaine. On physical examination there was a decreased range of motion of the cervical spine and a slight decrease in upper extremity strength. The lumbar examination noted an antalgic gait pattern. Sensation was also decreased. Patellar and Achilles reflexes were reported to be 3+ and hyperactive bilaterally. Diagnoses included anterior cervical microdiscectomy and interbody arthrodesis with retained hardware at C5-6 and C6-7, status post anterior microdiscectomy and interbody arthrodesis at C4-5, posterior cervical decompression and fusion from C3-C6, Chronic lumbosacral strain, moderate spinal stenosis at L2, L3, L4 with multiple foraminal stenosis, residual cervical myelopathy, significant cord gliosis involving majority of cervical spinal cord, moderate right foraminal stenosis at C2-C3 and C3-C4, bilateral moderate foraminal stenosis at C4-C5. The treatment plan included lumbar epidural injections and topical preparations. A request for topical Ketamine was sent.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ketamine HCL powder, Non-formulary DEA class III (topical pain) #360: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ketamine Section, Topical NSAIDS Page(s): 56, 113.

Decision rationale: According to the California MTUS Topical Ketamine is under study and is only recommended for treatment of neuropathic pain in refractory cases in which all primary and secondary treatment has been exhausted. In this case, pain is in the neck and lower back due to cervical and lumbar spinal canal stenosis, neural foraminal stenosis and status post anterior and posterior cervical fusion. The medical necessity for topical Ketamine is not met given the absence of neuropathy history.