

<b>Case Number:</b>	CM13-0062567		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	05/09/2001
<b>Decision Date:</b>	05/16/2014	<b>UR Denial Date:</b>	12/04/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/06/2013

### 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, Pain Medicine, and is licensed to practice in Florida. 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 injured worker is a 62-year-old female who reported an injury on 05/09/2001 after she attempted to move a patient with a draw sheet which reportedly caused a sudden onset of pain in her right arm. The injured worker's treatment history included surgical intervention, postoperative physical therapy, multiple medications, and home exercise program. The injured worker was evaluated on 10/03/2013. It was documented that the injured worker had ongoing Final Determination Letter for IMR Case Number CM13-0062567 3 pain complaints of the right upper extremity that were not resolved by physical therapy. The injured worker's medication schedule included ketamine 5% cream, pantoprazole, hydrocodone/APAP, Synovacin glucosamine, hydrochlorothiazide, and Zocor. Physical findings included distal upper extremities are within color, texture, or temperature changes and strength and range of motion were intact bilaterally. The injured worker's diagnoses included carpal tunnel syndrome, cervical disc displacement without myelopathy, pain in shoulder joint, and pain in hand joint. The injured worker's treatment plan included continuation of medications and trial of a muscle relaxant. A prescription refill was provided of cyclobenzaprine, hydrocodone/APAP, and ketamine 5% cream.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**KETAMINE CREAM:** Upheld

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

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

**Decision rationale:** The California Medical Treatment Utilization Schedule recommends the topical use of ketamine when all other first line and second line chronic pain management treatments have been exhausted. The injured worker has been injured since 2001. Therefore, the use of ketamine cream may be appropriate for this patient. However, the request as it is submitted does not clearly identify a frequency and duration of treatment. Therefore, the appropriateness of the request as it is submitted cannot be determined. As such, the request for ketamine cream is not medically necessary or appropriate.