MAXIMUS Federal Services

Case Number:	CM14-0107502		
Date Assigned:	08/01/2014	Date of Injury:	11/01/2011
Decision Date:	10/17/2014	UR Denial Date:	06/13/2014
Priority:	Standard	Application Received:	07/10/2014

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 Family Medicine 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 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 31 year old female injured on 11/01/11. Diagnoses include bilateral carpal tunnel syndrome, status post carpal tunnel release on the right, bilateral cubital tunnel syndrome, status post right ulnar transposition surgery, and bilateral shoulder rotator cuff tendonitis and impingement. Clinical note dated 04/14/14 indicated the injured worker presented complaining of bilateral upper extremity pain, status post debridement rotator cuff repair on 02/26/13, right ulnar nerve release of the right arm, and carpal tunnel release on the right wrist. The injured worker reported inflammation, pain, numbness in the right upper extremity following eight sessions of postoperative physical therapy. The injured worker reported good relief with pain medications consisting of approximately two to three tablets of Norco per day, Diclofenac cream, and Ketamine cream. Physical examination revealed normal muscle tone without atrophy to bilateral upper and lower extremities, decreased temperature to the right hand, normal capillary refill, bandage to the right elbow, and support brace to the left wrist. The initial request for Ketamine 5 percent 60 gram quantity one was initially noncertified on 06/13/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ketamine 5% cream 60gr #1: Upheld

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

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

Decision rationale: As noted in the Chronic Pain Medical Treatment Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Ketamine is 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 noncontrolled studies for complex regional pain syndrome (CRPS) I and postherpetic neuralgia and both have shown encouraging results. Without substantial evidence to support its use, Ketamine 5 percent cream 60 gram quantity one cannot be recommended as medically necessary.