

<b>Case Number:</b>	CM14-0123183		
<b>Date Assigned:</b>	08/08/2014	<b>Date of Injury:</b>	04/21/2008
<b>Decision Date:</b>	10/01/2014	<b>UR Denial Date:</b>	07/31/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/05/2014

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Pain 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 40-year-old male who reported an injury on 04/21/2008. The mechanism of injury was not provided for clinical review. The diagnoses included lumbar region sprain/strain, headache, major depression, pain psychogenic, and agoraphobia with panic attacks, chronic pain, and long term use of medication. The previous treatments included medication and gym membership. Within the clinical note dated 07/21/2014, it was reported the injured worker complained of chronic back, hip, and shoulder pain. He complained of anxiety and depression. The injured worker complained of no changes in his pain. Upon the physical examination, the provider noted the injured worker had normal muscle tone. The provider note the injured worker had no tenderness palpated in any extremity. The medication regimen included capsaicin cream, ketamine cream, hydrocodone/APAP, pantoprazole Protonix, mirtazapine, sumatriptan, gabapentin, and tramadol/APAP. The provider requested ketamine cream and tramadol for pain. The Request for Authorization was submitted; however, it was not dated.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ketamine 5% cream 60 gms:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSAID Page(s): 111-113.

**Decision rationale:** The request for Ketamine 5% cream 60 grams is not medically necessary. The California MTUS Guidelines note topical NSAIDs are recommended for osteoarthritis and tendinitis, in particular that of the knee and/or elbow and other joints that are amenable. Topical NSAIDs are recommended for short term use of 4 to 12 weeks. 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 of CRPS. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the treatment site. The request submitted failed to provide the frequency of the medication. Therefore, the request is not medically necessary.

**Tramadol/APAP 37.5/325 mg #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, On-Going Management Page(s): 78.

**Decision rationale:** The request for Tramadol/APAP 37.5/325 mg #90 is not medically necessary. The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend the use of a urine drug screen or inpatient treatment with issues of abuse, addiction, or poor pain control. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The provided failed to document an adequate and complete pain assessment within the documentation. Additionally, the use of a urine drug screen was not provided for clinical review. Therefore, the request is not medically necessary.