

<b>Case Number:</b>	CM14-0160414		
<b>Date Assigned:</b>	10/07/2014	<b>Date of Injury:</b>	09/25/2006
<b>Decision Date:</b>	11/07/2014	<b>UR Denial Date:</b>	09/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/30/2014

### 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 & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas & Oklahoma. 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 42-year-old male who reported an injury on 09/25/2006. The mechanism of injury was a fall. The injured worker's diagnoses included chronic pain syndrome and postlaminectomy syndrome. The injured worker's past treatments included injections, spinal cord stimulation, physical therapy, and medications. The injured worker's diagnostic testing included an MRI of the thoracic spine dated 05/04/2010, it was noted to reveal mild degenerative disc changes of the thoracic spine and mild thoracic dextroscoliosis. A lower extremity EMG dated 01/08/2008 was noted to reveal electrical findings consistent with a left L5 radiculopathy. The injured worker's surgical history included a microdiscectomy in 09/2007. On 09/18/2014, the injured worker complained of chronic low back pain and right knee pain. He reported to have low back pain that radiated into the left lower extremity. Upon physical examination, the injured worker was noted to have limited range of motion and evidence of discomfort with back flexion greater than extension. His strength was 5/5 in the lower extremities, proximally and distally. There was decreased sensation to pinprick and light touch in the approximate left L5-S1 distributions. The injured worker's medications included Norco 10/325 mg, gabapentin 600 mg, Lexapro 5mg, diclofenac sodium 1.5% at 60 gm, Protonix 20 mg, and docusate sodium 100 mg. The request was for ketamine 5% cream. The rationale for the request was not provided. The Request for Authorization form was signed and submitted on 09/22/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ketamine 5% cream 60gram #1: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Ketamine Page(s): 56.

**Decision rationale:** The California MTUS Guidelines state that ketamine is not recommended. There is insufficient evidence to support the use of ketamine for the treatment of chronic pain. There are no quality studies that support the use of ketamine for chronic pain. More studies are needed to further establish the safety and efficacy of this drug. One very small study concluded that ketamine showed a significant analgesic effect on peripheral neuropathic pain, but this clinical usefulness is limited by disturbing side effects. The documentation indicated that the injured worker used ketamine for neuropathic pain. The injured worker reported that he continued to have persistent back pain radiating down to his left lower extremity. The documentation did not provide sufficient evidence of the efficacy of the medication. There was no complete and thorough evaluation of his pain to include a quantified current pain, the least reported pain over the period since last assessment; intensity of pain after taking the opioid; and how long pain relief lasts. The documentation did not provide evidence of significant objective functional improvement or an objective decrease in pain in response to the use of ketamine. In the absence of documentation with sufficient evidence of significant objective functional improvements and documented evidence of an objective decrease in pain, the request is not supported. Additionally, as the request was written, there was no frequency provided. Furthermore, the guidelines do not recommend the use of the medication. As such, the request for ketamine 5% cream 60 gram #1 is not medically necessary.