

<b>Case Number:</b>	CM14-0076810		
<b>Date Assigned:</b>	07/18/2014	<b>Date of Injury:</b>	03/29/2005
<b>Decision Date:</b>	09/24/2014	<b>UR Denial Date:</b>	05/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/27/2014

### 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 Occupational 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 patient is a 55 year-old female with date of injury 03/29/2005. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 01/08/2014, lists subjective complaints as pain in the neck and shoulders with radicular symptoms down the upper extremities. Objective findings: No physical examination was performed or documented. The diagnosis is reflex sympathetic dystrophy. The medical records supplied for review document that the patient had been taking the following medications at for at least one month prior to the request for authorization on 01/08/2014. Medications include Ketamine 5% Cream SIG: apply a small amount twice a day.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective usage of Ketamine 5% cream:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 56, 111.

**Decision rationale:** The MTUS states that Ketamine is not recommended and that 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. In addition, there is little to no research to support the use of many of these Compounded Topical Analgesics. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Therefore, this request is not medically necessary.