

Case Number:	CM14-0094137		
Date Assigned:	07/25/2014	Date of Injury:	10/05/2008
Decision Date:	10/08/2014	UR Denial Date:	06/09/2014
Priority:	Standard	Application Received:	06/20/2014

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 Iowa. 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:

This patient is a 61 year-old male with a date of injury of 10/5/2008. A review of the medical documentation indicates that the patient is undergoing treatment for chronic pain in his low back and right foot pain. Subjective complaints (6/4/2014) include back pain, spasms, and stiffness. Objective findings (6/4/2014) include decreased range of motion in right foot and lumbar spine, tenderness to palpation at the lumbar spine, decreased R lower leg sensation, and decreased R leg motor strength. The patient has undergone imaging studies including MRI showing osteophyte complexes and foraminal narrowing at L3-L5 and EMG showing right sided axonal neuropathy and no lumbosacral radiculopathy. The patient has previously undergone injections and acupuncture therapy and there are conflicting statements on whether or not the patient has undergone lumbar surgery. A utilization review dated 6/9/2014 did not certify the request for Ketamine 5% cream 60gm QTY 1.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ketamine 5% cream 60gm QTY: 1.00: Upheld

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

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

Decision rationale: According to MTUS guidelines, use of Ketamine for chronic pain is not recommended. There is insufficient evidence to support its use and it is currently under study. It is only suggested for use in refractory cases of neuropathic pain in which all primary and secondary treatment has been exhausted. The medical records are limited in describing the need and rationale for prescribing Ketamine cream. The patient is on multiple other medications that would be considered first and second line therapies, and the patient has reported that these medications help with the pain. It does not appear from the medical documentation that all primary and secondary treatment options have been exhausted. The medical documentation does not provide any extenuating circumstances to justify adding this medication to the regimen. Therefore, the request for Ketamine 5% cream is not medical necessary.