

Case Number:	CM14-0196688		
Date Assigned:	12/04/2014	Date of Injury:	03/31/2009
Decision Date:	02/04/2015	UR Denial Date:	11/11/2014
Priority:	Standard	Application Received:	11/24/2014

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:

Patient is a 51 year-old female with date of injury 03/31/2009. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 10/22/2014, lists subjective complaints as pain in the bilateral shoulders. Patient is status post right shoulder arthroscopic rotator cuff repair in 2009. Objective findings: Examination of the right shoulder revealed tenderness to palpation of the acromioclavicular joint and restricted range of motion in all directions. Positive impingement sign and positive Neer's test. Weakness of the muscles of the rotator cuff were noted. Diagnosis: 1. Pain in joint, right shoulder. The medical records provided for review document that the patient has been taking the following medication for at least as far back as six months. Medication: 1. Ketamine 5% Cream 60 grams, #1 SIG: apply to affected area three times daily.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ketamine 5% cream 60gms, quantity 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111, 113.

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

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. Ketamine 5% cream 60gms, quantity 1 is not medically necessary.