

Case Number:	CM14-0197003		
Date Assigned:	12/05/2014	Date of Injury:	04/23/2004
Decision Date:	01/20/2015	UR Denial Date:	11/06/2014
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 Emergency 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 42 year-old female, who sustained an injury on April 23, 2004. The mechanism of injury was from cumulative trauma. Treatments have included: medications, botox injections. The current diagnoses are: major depression, lumbosacral neuritis/radiculitis, long-term use of medications, causalgia/ complex regional pain syndrome (CRPS) right upper extremity, lumbar radiculopathy, muscle spasm. The stated purpose of the request for Ketamine Hydrochloride #360, DOS: 10/29/14 was to provide pain control. The request for Ketamine Hydrochloride #360, DOS: 10/29/14 was denied on November 6, 2014, citing a lack of documentation of functional improvement. Per the report dated July 31, 2014, the treating physician noted complaints of pain to the right upper extremity, neck and jaw. Exam findings included right upper extremity guarding, tremor, allodynia, and no color change.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ketamine Hydrochloride #360, DOS: 10/29/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 38, 56.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ketamine Page(s): 38,56.

Decision rationale: The requested Ketamine Hydrochloride #360, DOS: 10/29/14, is not medically necessary. Chronic Pain Medical Treatment Guidelines, pages 38, 56, regarding Ketamine noted that Ketamine is not recommended for the treatment of chronic pain. The injured worker has pain to the right upper extremity, neck and jaw. The treating physician has documented right upper extremity guarding, tremor, allodynia, and no color change. The treating physician has not documented the medical necessity for this medication as an outlier to negative guideline recommendations, duration of treatment, nor objective evidence of derived functional improvement from previous use. The criteria noted above not having been met, this request is not medically necessary.