

<b>Case Number:</b>	CM15-0142542		
<b>Date Assigned:</b>	08/06/2015	<b>Date of Injury:</b>	11/24/1992
<b>Decision Date:</b>	09/25/2015	<b>UR Denial Date:</b>	06/17/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/22/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: California, Hawaii  
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 61 year old male, who sustained an industrial injury on November 24, 1992. The injured worker's initial complaints and diagnoses are not included in the provided documentation. The injured worker was diagnosed as having lumbar post-laminectomy syndrome. Diagnostic studies were not included in the provided medical records. Surgeries to date have included: lumbar spine surgery in 1993 and 1995. Treatment to date has included stretching, heat, a functional restoration program, epidural injections, and three topical analgesics. There were no noted previous injuries or dates of injury, and no noted comorbidities. On May 13, 2015, the injured worker reported ongoing, constant, sharp lower back pain radiating down the left leg. His pain is rated 3-4 out of 10 with rest and 6 out of 10 with activities. His pain is improved with rest, medications, stretching, walking, and heat. The physical exam revealed normal musculoskeletal muscle tone and strength of the bilateral lower extremities, and antalgic gait, decreased sensation in the left lumbar 3 through sacral 1 dermatomes, a negative straight leg raise, 3+ deep tendon reflexes of the bilateral patellae, absent left Achilles deep tendon reflex, and a normal right Achilles deep tendon reflex. His work status was described as permanent and stationary. The treatment plan includes continuing the Capsaicin 0.075% cream and Ketamine 5% cream.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retro Capsaicin 0.075% cream 2% (DOS 5/13/15): 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 Topical Analgesics Page(s): 111-113.

**Decision rationale:** The patient presents with pain affecting the low back with radiation down the left leg. The current request is for Retro Capsaicin 0.075% cream 2% (DOS 5/13/15). The treating physician report dated 5/13/15 (39B) states, "He uses Capsaicin 0.075% cream and Ketamine 5% cream, and applies it on the affected areas 3 times per day, which he finds effective with no side effects. These were refilled." The MTUS guidelines page 111 regarding topical NSAIDs states, "Indications: Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short term use (4-12 weeks)." The medical reports provided show the patient has been using Capsaicin since at least 2/18/15(23B). In this case, the patient presents with pain affecting the low back and the MTUS guidelines only support topical NSAIDs for the treatment of Osteoarthritis of the knee or other joints that are amenable to topical treatment. Furthermore, topical NSAIDs are only recommended for 4-12 weeks and the patient has been prescribed this medication since at least 2/18/15. The current request does not satisfy the MTUS guidelines as outlined on pages 111-113. The current request is not medically necessary.

**Retro Ketamine 5% cream 60gm (DOS 5/13/15): 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 Topical Analgesics Page(s): 111-113.

**Decision rationale:** The patient presents with pain affecting the low back with radiation down the left leg. The current request is for Retro Ketamine 5% cream 60gm (DOS 5/13/15). The treating physician report dated 5/13/15 (39B) states, "He uses Capsaicin 0.075% cream and Ketamine 5% cream, and applies it on the affected areas 3 times per day, which he finds effective with no side effects. These were refilled." The MTUS guidelines regarding topical ketamine states, "Ketamine: Under study: Only recommended for treatment of neuropathic pain in refractory cases in which all primary and secondary treatment has been exhausted. Topical ketamine has only been studied for use in non-controlled studies for CRPS I and post-herpetic neuralgia and both have shown encouraging results. The exact mechanism of action remains undetermined. (Gammaitoni, 2000) (Lynch, 2005) See also Glucosamine (and Chondroitin Sulfate)" The medical reports provided show the patient has been using Ketamine since at least 2/18/15(23B). In this case, the patient presents with pain affecting the low back and the MTUS guidelines only support topical NSAIDs for the treatment of Osteoarthritis of the knee or other joints that are amenable to topical treatment. Furthermore, under ketamine, MTUS states that it

is currently under study and is only recommended for treatment of neuropathic pain and refractory cases in which all primary and secondary treatment have been exhausted. The PA states that there have been no trial of an anti-depressant, which is considered a primary treatment for neuropathic pain. While the injury dates back to 1992, the medical records provided do not document the necessary criteria for medical necessity. The current request does not satisfy the MTUS guidelines as outlined on pages 111-113. The current request is not medically necessary.