

<b>Case Number:</b>	CM15-0188213		
<b>Date Assigned:</b>	09/30/2015	<b>Date of Injury:</b>	09/18/1998
<b>Decision Date:</b>	11/09/2015	<b>UR Denial Date:</b>	09/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/24/2015

### 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: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular Medicine

### 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 51 year old male who sustained an industrial injury on 9-18-1998. A review of medical records indicates the injured worker is being treated for degeneration of lumbar or lumbosacral intervertebral disc, complex regional pain syndrome, and lumbar post laminectomy syndrome. Medical records dated 7-6-2015 noted low back pain without medication was rated a 9 out 10 and with medications a 4-5 out 10. Pain medication continued to keep pain within a manageable level and allow him to complete necessary activities of daily living. Pain was the same since the last visit. Physical examination noted a moderate positive straight leg raise bilaterally. Lumbar range of motion was restricted. MRI of the lumbar spine dated 6-12-2002 revealed enhancing fibrosis and bilateral posterolateral disc bulging as on the previous examination from 1-22-1999. Treatment has included activity restriction, rest, Norco, Soma, Lidoderm patches, and Ketamine cream since at least 3-3-2015. Utilization review form dated 9-6-2015 noncertified CAP cream Ketamine 10% 60 grams.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CAP cream Ketamine 10% 60grams:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Ketamine, Topical Analgesics.

**Decision rationale:** CAP cream Ketamine 10% 60grams is not medically necessary per the MTUS guidelines. The MTUS states that topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The MTUS Chronic Pain Medical Treatment Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. There is little to no research to support the use of many of these agents. The MTUS states 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, but it is under study for CRPS. The guidelines states that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The request is not medically necessary as there is not overwhelming evidence to support the use of Ketamine for CRPS. The documentation does not indicate that the patient has failed trials of antidepressants or anticonvulsants or all other methods of treatment. The request for CAP cream Ketamine 10% 60 grams is not medically necessary.