

<b>Case Number:</b>	CM14-0163363		
<b>Date Assigned:</b>	10/08/2014	<b>Date of Injury:</b>	09/12/1997
<b>Decision Date:</b>	11/12/2014	<b>UR Denial Date:</b>	09/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/03/2014

### 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 Neurology, has a subspecialty in Neuromuscular Medicine and is licensed to practice in New Jersey. 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 patient is a 55-year-old woman who sustained a work-related injury on September 12, 1997. Subsequently, she developed chronic low back pain. The patient underwent an IDET procedure in 1998 with only minimal benefits and lumbar fusion surgery by anterior and posterior approach at the L3-L5 levels on December 6, 2009. This procedure was somewhat helpful in decreasing her pain and she was able to actually ambulate for greater distances; however, she fell in 2011 and developed increasing lower back pain and pain going into the lower extremities. She has had extensive conservative management including physical therapy, epidural injections, lumbar brace support and oral medicines. MRI of the lumbar spine done May 16, 2014 showed interval postsurgical findings of anterior and posterior fusion at L3-4 and L4-5 with posterior hardware, decompression of the central canal and there is solid anterior bony fusion with interbody grafts. There is no visualized nerve root compression at these postsurgical levels. At L2-3, 3-4 mm annular disc bulge and facet hypertrophy with moderate central canal narrowing, moderate right and mild left neural foraminal narrowing. Findings have progressed from prior study at this level. There is also a new type 1 marrow end-plate changes at the L2 inferior end-plate. The EMG study of bilateral upper extremities performed on August 17, 2009 showed electrodiagnostic evidence of left L5 radiculopathy and findings suggestive, but not diagnostic, of mild, chronic, right L5-S1 radiculopathy. There was no electrodiagnostic evidence of right or left lumbosacral plexopathy. According to a visit note dated September 25, 2014, the patient reported persistent low back pain radiating down her left lower extremity mainly at the left hip. She has been authorized to begin functional restoration program to improve physical function and pain coping skills. The patient reported that medications have been effective at reducing her low back pain however she reported stomach upset from her medications. Her physical examination of the lumbar spine revealed tenderness to palpation at the lumbosacral junction with reduced range of

motion. Deep tendon reflexes were 1+ and equal at the patella and Achilles. Clonus as negative bilaterally, Straight leg raise was negative bilaterally. The patient was diagnosed with spondylosis lumbosacral, lumbar disc displacement without myelopathy, cervical disc displacement, and stenosis spinal lumbar. The provider is requesting authorization for Ketamine 5% Cream.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Ketamine 5% Cream #60 Grams, Apply to Affected Area 3 Times a Day, #1:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

**Decision rationale:** According to MTUS, in Chronic Pain Medical Treatment guidelines section Topical Analgesics (page 111), topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Many agents are combined to other pain medications for pain control. That is limited research to support the use of many of these agents. Furthermore, according to MTUS guidelines, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. There is no evidence that Ketamine cream is recommended as topical analgesics for chronic back pain. Ketamine cream, a topical analgesic is not recommended by MTUS guidelines. Based on the above Ketamine 5% cream is not medically necessary.