

Case Number:	CM15-0166352		
Date Assigned:	09/11/2015	Date of Injury:	03/12/2013
Decision Date:	11/09/2015	UR Denial Date:	07/31/2015
Priority:	Standard	Application Received:	08/24/2015

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: Texas, California

Certification(s)/Specialty: Family Practice

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 60-year-old male worker with a date of injury 3-12-2013. The medical records indicated the injured worker (IW) was treated for cervical disc displacement without myelopathy; degeneration of cervical disc; cervical spinal stenosis; and cervical spondylosis without myelopathy. In the 6-11-15 and 7-20-15 progress notes, the IW reported neck pain with radiation of numbness and tingling to the bilateral upper extremities, worse on the right. The IW was "permanent and stationary." Objective findings on 6-11-15 and 7-20-15 included muscle strength without deficit in the bilateral upper extremities. There was spasm and hypertonicity in the cervical paraspinal and upper trapezius musculature. Treatments included medications (topical Ketamine), physical therapy (no benefit) and epidural steroid injection (no benefit). A Request for Authorization was received for Ketamine 5% cream 60 gr, apply to affected area three times daily, #1. The Utilization Review on 7-31-15 non-certified the request for Ketamine 5% cream 60 gr, as Ketamine is not recommended by CA MTUS guidelines. The patient sustained the injury due to cumulative trauma. Per the note dated 9/1/15, the patient had complaints of chronic neck pain with radiation of pain and numbness and tingling in bilateral upper extremities. The patient has had stiffness in neck and difficulty in looking down. Physical examination revealed decreased sensation in C6-7 dermatome and decreased sensation and strength in upper extremity. The patient has a MRI of cervical spine that revealed disc protrusions and central canal stenosis; EMG of upper extremity that revealed CTS. The patient has had tried previously Buprenorphine, Norflex, Flexeril and Anaprox and cervical ESI without benefit in pain. The patient had received an unspecified number of massage, chiropractic,

acupuncture and PT visits for this injury. A recent detailed clinical examination of the gastrointestinal tract was not specified in the records provided. On review of system, the patient does not have any complaints of gastrointestinal tract. The patient's surgical history includes removal of mass from testicle.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ketamine 5% cream 60 gr, apply to affected area three times a day #1: 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): Topical Analgesics.

Decision rationale: Request: Ketamine 5% cream 60 gr, apply to affected area three times a day #1. According to the MTUS Chronic Pain Guidelines regarding topical analgesics, the use of topical analgesics is "Largely experimental in use with few randomized controlled trials to determine efficacy or safety, primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." Per the cited guidelines, "Ketamine: Under study: Only recommended for treatment of neuropathic pain in refractory cases in which all primary and secondary treatment has been exhausted." MTUS guidelines recommend topical analgesics for neuropathic pain only when trials of antidepressants and anticonvulsants have failed to relieve symptoms. A detailed response of trial of antidepressants and anticonvulsants for these symptoms were not specified in the records provided. Evidence of intolerance or contraindication to oral medications was not specified in the records provided. Ketamine 5% cream 60 gr, apply to affected area three times a day #1 is not medically necessary in this patient.