

<b>Case Number:</b>	CM14-0034948		
<b>Date Assigned:</b>	06/23/2014	<b>Date of Injury:</b>	09/05/2002
<b>Decision Date:</b>	07/22/2014	<b>UR Denial Date:</b>	03/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/20/2014

### 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 Occupational Medicine and is licensed to practice in New York and North Carolina. 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 74-year-old woman, injured on 9/25/02 (mechanism unknown) when employed as a clerk-typist, with resultant bilateral knee pain and back pain. She has been diagnosed with right knee chondromalacia and meniscal tear and left knee compensatory pain, and lumbar strain. She complains of ongoing low back pain, described as aching with burning left groin pain. She is appealing the denial of two topical compounds for pain management.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Amitramadol-DM ultra cream 4/20/10% 240gm apply 2-3 times a day:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113. Decision based on Non-MTUS Citation International Journal of Pharmaceutical Compounding, vol 15, no. 3: 2011.

**Decision rationale:** Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. There is one compound, unnamed, found composed of amitriptyline 4%, dextromethorphan hydrobromide 20% and tramadol hydrochloride 5% in a gel. (International Journal of Pharmaceutical Compounding, vol 15, no. 3: 2011). None of the

components of this compound is approved under the MTUS Chronic Pain Guidelines; hence, this compound is not medically necessary.

**Gapapentin/ketoprofen/lidoderm HCL 5/20/6.15% 240 gm cream:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics (Compounded Medications).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

**Decision rationale:** Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Gabapentin is not recommended per MTUS Chronic Pain Guidelines. Ketoprofen is not FDA approved for topical use. The request for this topical combination is not medically necessary.