

Case Number:	CM14-0043990		
Date Assigned:	06/20/2014	Date of Injury:	05/14/1999
Decision Date:	07/31/2014	UR Denial Date:	03/11/2014
Priority:	Standard	Application Received:	03/18/2014

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 California. 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 48-year-old male with date of injury 05/14/1999. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 01/31/2014, lists subjective complaints as pain in the right knee. The objective findings included an examination of the right knee revealed tenderness to palpation along the medial joint line. A Valgus/varus stress test aggravated the patient's pain. The patient's range of motion was restricted in all planes. The patient complains symptoms worsen with prolonged walking. The patient's diagnosis included right knee arthrosis with chondromalacia, right knee degenerative joint disease status post right knee arthroscopy. No documentation was provided for review that would indicate that the patient has been prescribed the following medication before the request for authorization on 03/19/2014. The medications requested includes Amitramadol-DM Ultracream 4/20/10%, 240gm and Gabaketilido 6/20/6.15%, 240gm.

IMR ISSUES, DECISIONS AND RATIONALES

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

Amitramadol-DM Ultracream 4/20/10%, 240gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Medications. Decision based on Non-MTUS Citation Official Disability Guidelines, Topical Applications and National guidelines clearinghouse, Topical medications.

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

Decision rationale: The compound contains Amitriptyline, Dextromethorphan, and Tramadol. None of these medications are recommended by the MTUS as topical agents. According to the MTUS, there is little to no research to support the use of many of these compounded topical analgesics. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Amitramadol-DM Ultracream 4/20/10%, 240gm is not medically necessary.

Gabaketolido 6/20/6.15%, 240gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Medications. Decision based on Non-MTUS Citation Official Disability Guidelines, Topical Applications and National guidelines clearinghouse, Topical medications.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-112.

Decision rationale: According to the MTUS, there is little to no research to support the use of many of these Compounded Topical Analgesics. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The compound contains Ketoprofen and is not currently FDA approved for a topical application. It has an extremely high incidence of photocontact dermatitis. Gabaketilido 6/20/6.15%, 240gm is not medically necessary.