

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review
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Notice of Independent Medical Review Determination

Dated: 11/27/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/15/2013
Date of Injury:	2/8/2012
IMR Application Received:	7/29/2013
MAXIMUS Case Number:	CM13-0004494

- 1) MAXIMUS Federal Services, Inc. has determined the request for **Deprizine 15mg/ml oral suspension 250ml** is not medically necessary and appropriate.
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Dicopanol 5mg/ml oral suspension 150ml** is not medically necessary and appropriate.
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Fanatrex 25mg/ml oral suspension 420ml** is not medically necessary and appropriate.
- 4) MAXIMUS Federal Services, Inc. has determined the request for **Synapryn 10mg/ml oral suspension 500ml** is not medically necessary and appropriate.
- 5) MAXIMUS Federal Services, Inc. has determined the request for **Tabradol 1mg/ml oral suspension 250ml** is not medically necessary and appropriate.
- 6) MAXIMUS Federal Services, Inc. has determined the request for **Cyclophene 5% in PLO gel, 120gm** is not medically necessary and appropriate.
- 7) MAXIMUS Federal Services, Inc. has determined the request for **Ketoprofen cream 20% in PLO gel 120gm** is not medically necessary and appropriate.
- 8) MAXIMUS Federal Services, Inc. has determined the request for **MRI of right knee** is not medically necessary and appropriate.

- 9) MAXIMUS Federal Services, Inc. has determined the request for **physical therapy 3 times a week for 6 weeks** is not medically necessary and appropriate.
- 10) MAXIMUS Federal Services, Inc. has determined the request for **chiropractic manipulation 3 times a week for 6 weeks for right knee** is not medically necessary and appropriate.
- 11) MAXIMUS Federal Services, Inc. has determined the request for **urinalysis** is not medically necessary and appropriate.

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/29/2013 disputing the Utilization Review Denial dated 7/15/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/9/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the request for **Deprizine 15mg/ml oral suspension 250ml** is not medically necessary and appropriate.
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Dicopanol 5mg/ml oral suspension 150ml** is not medically necessary and appropriate.
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Fanatrex 25mg/ml oral suspension 420ml** is not medically necessary and appropriate.
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- 9) MAXIMUS Federal Services, Inc. has determined the request for **physical therapy 3 times a week for 6 weeks** is not medically necessary and appropriate.
- 10) MAXIMUS Federal Services, Inc. has determined the request for **chiropractic manipulation 3 times a week for 6 weeks for right knee** is not medically necessary and appropriate.
- 11) MAXIMUS Federal Services, Inc. has determined the request for **urinalysis** is not medically necessary and appropriate.

Medical Qualifications of the Expert Reviewer:

The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, 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 treatments and/or services at issue.

Expert Review Summary:

This claimant is a 50-year-old male with complaints of pain. On 03/08/2013 he was seen in clinic. At that time he was described working as a gardener, performing multiple repetitive jobs, including standing, bending, climbing stairs, and kneeling at a frequency of up to 8 hours per day. He stated that on 08/13/2009 and 02/08/2012, he was involved in work-related accidents, as a result of which he sustained injuries to his right knee and abdomen. He stated he was mowing the lawn and the machine got stuck on the cement and hit him in the abdomen and he felt immediate, severe pain. On 02/08/2012, he was in the process of cutting down with 2 other coworkers and while moving a tree to a vehicle he started feeling pain to his right knee. He is now status post abdominal surgery with residual pain rated at 5/10 to 10/10 and has pain related to his knee as well. Knee pain was rated at 5/10 to 10/10 as well. On exam he walks with an antalgic gait and is able to perform heel and toe walk, and has pain with heel walking. He has tenderness to palpation at the medial joint line of the right knee and to the patellofemoral joint and there is also tenderness to palpation over the pes anserine bursa. He has no anterior or posterior cruciate ligament instability and there was no medial or lateral collateral ligament instability noted. Range of motion of the right knee is 120 degrees of flexion and 0 degrees extension and this is described as normally being 140 degrees and 0 degrees respectively. Apley's compression test was positive, as was patellofemoral compression test. He was prescribed medications at that time. Medications included oral medications, including Deprizine, Dicopanol, Fanatrex, Synapryn, Tabradol, Cyclophene, ketoprofen cream; all of which, except for ketoprofen cream, were described as having proprietary ingredients. He returned to clinic on unstated date with evaluation by [REDACTED], MD. He complained of pain to his right knee rated at 6/10. Examination of his right knee revealed tenderness to palpation about the medial joint line. He had no anterior/posterior ligament instability, no medial and lateral instability. He had 125 degrees of flexion and 0 degrees of extension to the right knee. McMurray's test was positive to the right knee. He was again continued on same medications.

Documents Reviewed for Determination:

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application of Independent Medical Review
- Utilization Review Determination CompPartners
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for Deprizine 15mg/ml oral suspension 250ml :
Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, NSAIDs, GI symptoms & cardiovascular risk, page 68, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Use of NSAIDs and SSRIs, page 69, which is part of the MTUS.

Rationale for the Decision:

This medication is used for short-term treatment of active duodenal ulcers or for maintenance therapy for duodenal ulcer patients or for short-term treatment of active benign gastric ulcers or for maintenance therapy for gastric ulcer patients at reduced dosage after healing acute ulcer or for treatment of GERD or endoscopically diagnosed erosive esophagitis or for maintenance and healing of erosive esophagitis. Medical records submitted for review that this medication has proprietary ingredients that are unknown at that time. The medical records fail to indicate if the employee has significant gastrointestinal issues, GERD, or has been diagnosed as having a gastric ulcer. The records reviewed also indicate that this medication has been shown to be safe and effective in the treatment of mild to moderate insomnia, however there is no documentation supporting any evidence of significant insomnia. **The request for Deprizine 15mg/ml oral suspension 250ml is not medically necessary and appropriate.**

2) Regarding the request for Dicopanl 5mg/ml oral suspension 150ml :
Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Claims Administrator based its decision on the Official Disability Guidelines (ODG), Pain, Insomnia treatment, which is not part of the MTUS.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on the Physician Office Resource.

Rationale for the Decision:

The medication requested contains gabapentin, and is a compounded medication with proprietary ingredients that are unstated and unknown at this time. The treating physician indicated that gabapentin has also been shown to be well tolerated and useful for acute postoperative pain or patients with spinal cord injury or chronic low back pain. A review of the submitted medical records does not indicate if this employee has had acute postoperative pain, spinal cord injury, or chronic low back pain, nor is there any evidence of the efficacy of this

medication. **The request for Dicopanol 5mg/ml oral suspension 150ml is not medically necessary and appropriate.**

**3) Regarding the request for Fanatrex 25mg/ml oral suspension 420ml :
Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision:**

The Claims Administrator based its decision on the Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Antiepilepsy drugs (AEDs), page 16 & 18, Glucosamine, page 50, which is part of the MTUS, the Official Disability Guidelines, Pain, Compounded Drugs, which is not part of the MTUS, and the US National Institute of Health (NIH) National Library of Medicine (NLM) PubMed, 2013, which is not part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Gabapentin, anit-epilepsy drug (AED), page 49, which is part of the MTUS and FDA, contents, gabapentin, which is not part of the MTUS

Rationale for the Decision:

A review of the submitted medical records indicates that Fanatrex includes gabapentin and other proprietary ingredients. Gabapentin is for neurogenic pain. The records reviewed indicate that this medication has proprietary ingredients, which are unstated and unknown. The medical records lack of evidence to support that there is a significant functional improvement with this medication. **The request for Fanatrex 25mg/ml oral suspension 420ml is not medically necessary and appropriate.**

**4) Regarding the request for Synapryn 10mg/ml oral suspension 500ml :
Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision:**

The Claims Administrator based its decision on the Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Glucosamine, page 50, Opioids-Tramadol, page 91-94, which is part of the MTUS, and the US National Institute of Health (NIH) National Library of Medicine (NLM), PubMed, 2013, which is not part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Tramadol (Ultram), pages 78 & 113, part of the MTUS and the Mayo Clinic, which is not part of the MTUS.

Rationale for the Decision:

The requesting provider indicates this medication has tramadol and glucosamine, as well as other proprietary ingredients. With this medication containing tramadol, there should be documentation of urine drug screens to demonstrate efficacy as requested by the Chronic Pain Medical Treatment Guidelines when they discuss the “4 A’s”, analgesia, activities of daily living, adverse side effects, and aberrant-drug taking behavior. Chronic Pain Medical Treatment Guidelines also discuss glucosamine, “note glucosamine sulfate has demonstrated efficacy, but glucosamine hydrochloride does not.” The medical records submitted for review do not indicate if the glucosamine in this medication is “glucosamine hydrochloride” or “glucosamine sulfate” that is compounded into this medication. Without the other unnamed proprietary ingredients and documentation of efficacy of this medication it is difficult to know if this medication would meet the criteria set forth in the Chronic Pain guidelines. **The request for Synapryn 10mg/ml oral suspension 500ml is not medically necessary and appropriate.**

5) Regarding the request for Tabradol 1mg/ml oral suspension 250ml :
Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Claims Administrator based its decision the Chronic Pain Medical Treatment Guidelines, Cyclobenzaprine (Flexeril), Muscle relaxants for pain, page 63, which is part of the MTUS and the US National Institute of Health (NIH) National Library of Medicine (NLM), PubMed, 2013, which is not part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Cyclobenzaprine, pages 41-42, which is part of the MTUS

Rationale for the Decision:

Chronic Pain guidelines recommend this medication as an option using a short course of therapy. The submitted medical records do not indicate the overall efficacy of this medication and indicates that the employee has been on this medication since at least 03/08/2013. Due to the nature of the medication, long-term use of this medication is not supported by guidelines. Overall efficacy has not been demonstrated. **The request for Tabradol 1mg/ml oral suspension 250ml is not medically necessary and appropriate.**

6) Regarding the request for Cyclophene 5% in PLO gel, 120gm :
Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Topical Analgesics, page 111, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Topical Analgesics, page 111-113

Rationale for the Decision:

Chronic Pain guidelines indicate that topical analgesics are largely experimental in use with few randomized controlled trials to demonstrate efficacy or safety. The medical records submitted for review indicates this medication contains cyclobenzaprine, as well as other proprietary ingredients that have not been documented. The records indicate that the employee is already getting Flexeril or cyclobenzaprine in another medication, and the rationale for providing another form of this medication has not been demonstrated by the records. Overall efficacy of this medication has not been established in the records provided. **The request for Cyclophene 5% in PLO gel, 120gm is not medically necessary and appropriate.**

7) Regarding the request for Ketoprofen cream 20% in PLO gel 120gm :
Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Topical Analgesics, page 111, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Topical Analgesics, page 111-113, which is part of the MTUS.

Rationale for the Decision:

Chronic Pain Medical Treatment Guidelines indicate that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical NSAIDs have been shown to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward or with a diminished effect over another 2 week period. Guidelines indicate that no long studies have been performed to demonstrate their efficacy or safety. The review of medical records submitted does not indicate that this medication has demonstrated overall efficacy for this employee. **The request for Ketoprofen cream 20% in PLO gel 120gm is not medically necessary and appropriate.**

8) Regarding the request for MRI of right knee :
Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Claims Administrator based its decision on the American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 14, page 341, which is part of the MTUS.

The Expert Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Knee

Chapter, pages 341-343, which is part of the MTUS and the Official Disability Guidelines (ODG), Knee Chapter, MRI's, which is not part of the MTUS.

Rationale for the Decision:

ACOEM Guidelines indicate that special studies are not needed to evaluate most knee complaints until after a period of conservative care and observation. A review of the submitted medical records do not document that the employee has had an X-ray, evidence that the employee has failed lesser measures, such as physical therapy, or that the employee has tried and failed conservative care.

The request for an MRI of the right knee is not medically necessary and appropriate.

9) Regarding the request for physical therapy 3 times a week for 6 weeks :
Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Physical Medicine, pages 98-99, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Physical Medicine, pages 98-99, which is part of the MTUS.

Rationale for the Decision:

Chronic Pain Medical Treatment Guidelines indicate that for myalgia and myositis, 9 to 10 visits over 8 weeks may be considered reasonable and necessary, and for neuralgia, neuritis, and radiculitis, 8 to 10 visits over 4 weeks would be considered reasonable. The medical records submitted for review indicate that the employee has myalgia and myositis of the knee and of the lower extremity. The records reviewed do not indicate any significant functional deficits, such as significant decreased range of motion or significant strength for which physical therapy would be appropriate. This request exceeds guideline recommendations at this time. **The request for physical therapy 3 times a week for 6 weeks is not medically necessary and appropriate.**

10) Regarding the request for chiropractic manipulation 3 times a week for 6 weeks for right knee :

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Manual therapy and manipulation, page 58, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Knee Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 13) pg 337, and the Chronic Pain Medical Treatment Guidelines, Manual therapy and manipulation, pages 58-59, which are part of the MTUS.

Rationale for the Decision:

California MTUS/ACOEM indicates, "Manipulation does not appear to be effective in alleviating knee pain." Review of the submitted medical records lack documentation of significant functional deficits, such as significant decreased range of motion to support the request for chiropractic care. **The request for chiropractic manipulation 3 times a week for 6 weeks is not medically necessary and appropriate.**

11)Regarding the request for urinalysis :

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Drug testing, page 43, which is part of the MTUS.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on the Merck manual, Urinalysis.

Rationale for the Decision:

Merck Manual indicates that urinalysis would include inspection for color, appearance, and odor or for analysis for casts, crystals, and cells. A review of the medical records failed to describe any significant renal issues or bladder issues for which this study would be appropriate. **The request for a urinalysis is not medically necessary and appropriate.**

Effect of the Decision:

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

/db

Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.