MAXIMUS Federal Services

| Case Number: | CM13-0006830 | | |
|---|---|---|---|
| Date Assigned: | 11/08/2013 | Date of Injury: | 04/14/2004 |
| Decision Date: | 01/13/2014 | UR Denial Date: | 07/08/2013 |
| Priority: | Standard | Application Received: | 08/05/2013 |

## HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician 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 physician 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 applicant is a 43 year injured worker with a date of injury of April 14, 2004. Thus far, the applicant has been treated with the following: Analgesic medications; prior lumbar fusion surgery; topical compounds; oral suspension; epidural steroid injections; and extensive periods of time off of work, and is on total temporary disability. In a utilization review report of July 8, 2013, the claims administrator noncertified several topical compounds and an oral suspension. The applicant later appealed, on July 29, 2013. An earlier note of June 7, 2013, is notable for comments that the applicant reports persistent 6-7/10 mild-to-moderate low back pain. The medications only offer temporary relief. The applicant is asked to continue physical therapy and employ various topical compounds and oral suspensions while remaining off of work, on total temporary disability.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Ketoprofen 20%, 120gm:** Upheld

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

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

**Decision rationale:** According to the MTUS Chronic Pain Medical Treatment Guidelines, Ketoprofen is not recommended or endorsed for topical compound use purposes owing to high incidence of adverse effects noted by the Foods and Drug Administration (FDA). Since the key ingredient in the compound carries an unfavorable recommendation, the entire compound is considered to carry an unfavorable recommendation, per page 111 of the MTUS Chronic Pain Medical Treatment Guidelines. The request for 1 prescription of compounded Ketoprofen 20 percent, 120gm, is not medically necessary and appropriate.

**Cyclophene 5%, 120gm:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47,Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

**Decision rationale:** According to the MTUS Chronic Pain Medical Treatment Guidelines, topical analgesic is considered "largely experimental." In this case, there is no evidence of the employee having intolerance to and/or failure of first line oral analgesics. The request for 1 prescription of compounded Cyclophene 5 percent, 120mg, is not medically necessary and appropriate.

**Deprizine 15mg/ml oral suspension 250ml:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter..

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 69. Decision based on Non-MTUS Citation the National Library of Medicine, Ranitidine (Deprizine).

**Decision rationale:** According to the MTUS Chronic Pain Medical Treatment Guidelines, pg.69, endorses the usage of H2 antagonist such as ranitidine (Deprizine) in the treatment of NSAID-induced dyspepsia. In this case, however, there is no mention of any signs or symptoms of dyspepsia, either NSAID-induced or standalone. The request for 1 prescription of Deprizine 15gm/ml oral suspension 250ml is not medically necessary and appropriate.

**Fanatrex 25mg/ml oral suspension 420ml:** Upheld

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

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

**Decision rationale:** The Physician Reviewer's decision rationale: According to the National Library of Medicine, Fanatrex is a gabapentin containing a suspension/compound. The MTUS Chronic Pain Medical Treatment Guidelines, does not recommend Gabapentin and state that this drug is for compound usage purposes, resulting in the entire compound's carrying an unfavorable recommendation. The request for Fanatrex 25mg/ml oral suspension 420 ml, is not medically necessary and appropriate.

**Synapryn 10mg/ml oral suspension 250ml:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 50.

**Decision rationale:** The Physician Reviewer's decision rationale: According to the MTUS Chronic Pain Medical Treatment Guidelines, glucosamine is recommended as an option in the treatment knee arthritis. In this case, however, there is no clear clinical or radiographic evidence of knee arthritis for which usage of glucosamine would be indicated. The request for Synapryn 10mg/ml suspension 250 ml, is not medically necessary and appropriate.

**Dicopanol 5mg/ml oral suspension 150ml:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation the National Library of Medicine.

**Decision rationale:** The MTUS does not address the topic. As noted by the National Library of Medicine, Dicopanol or diphenhydramine is used to treat allergic reactions, motion sickness, and symptoms of Parkinson's disease. In this case, however, there is no evidence or description of parkinsonism, motion sickness, and/or allergic reactions for which usage of Benadryl would be indicted. The request for 1 prescription of Dicopanol 5mg/ml suspension 150 ml, is not medically necessary and appropriate.

**Tabradol 1mg/ml oral suspension 250ml:** Upheld

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

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

**Decision rationale:** According to the National Library of Medicine, Tabradol is a cyclobenzaprine-containing compound. However, Page 113 of the MTUS Chronic Pain Medical

Treatment Guidelines notes that muscle relaxants such as cyclobenzaprine are not recommended for compound use purposes, resulting in the entire compound's carrying an unfavorable recommendation. The request for 1 prescription of Tabradol 1mg/ml oral suspension 250ml, is not medically necessary and appropriate.

**6 Shockwave therapy sessions:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Offical Disability Guidelines-Low Back-Lumbar & Thoracic (Acute & Chronic)..

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints, Chapter 9 Shoulder Complaints.

**Decision rationale:** The MTUS-ACOEM Guidelines, Ankle and Foot Complaints Chapter, endorses the usage of extracorporeal shockwave therapy in the treatment of radiographically confirmed calcifying tendinitis. Additionally, the MTUS/ACOEM Guidelines, Shoulder Complaints Chapter, endorses extracorporeal shockwave therapy in the treatment of chronic plantar fasciitis. In this case, however, there is no evidence that the employee carries either diagnosis calcifying tendinitis of the shoulder and/or plantar fasciitis of the foot for which extracorporeal shockwave therapy would be indicated. The request for 6 shockwave therapy sessions is not medically necessary and appropriate.