

<b>Case Number:</b>	CM14-0063374		
<b>Date Assigned:</b>	08/08/2014	<b>Date of Injury:</b>	09/29/2013
<b>Decision Date:</b>	09/11/2014	<b>UR Denial Date:</b>	04/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/05/2014

### 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 Orthopedic Surgery 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 claimant is a 60-year-old female injured in a work related accident 09/29/13. Injury was sustained to the left knee. Recent clinical assessment for review includes a 03/11/14 progress report where the claimant was with complaints of knee pain bilateral lower extremity pain, low back pain, neck pain, thigh pain and radiating pain to the bilateral feet and ankles. Objectively there was tenderness noted to the cervical spine to palpation, the lumbar spine to palpation with restricted range of motion and lower extremity examination that showed use of a knee brace, a +1 effusion, medial joint line tenderness and positive crepitation to the left knee. There were recommendations for treatment at that time that included use of shock wave therapy to the left knee, Terocin patches, topical compounds as well as oral suspensions including Synapryn, Tabradol, Deprizine, Dicopanl and Gabapentin.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **Shockwave Therapy for Left Knee: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) -- Official

Disability Guidelines Treatment in Worker's Comp, 18th Edition, 2013 Updates: Knee Procedure.

**Decision rationale:** California MTUS ACOEM Guidelines are silent regarding the use of shockwave therapy for the knee. When looking at Official Disability Guidelines criteria, this form of modality would not be indicated. Currently, there is no indication of studies or randomized clinical trials demonstrating efficacy of shock wave treatment in the setting of the knee. The request in this case is not medically necessary.

**Terocin Patches:** Upheld

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

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

**Decision rationale:** California MTUS ACOEM Chronic Pain Medical Treatment Guidelines would not support the use of Terocin patches. Terocin patches are a combination of Menthol and lidocaine. The topical use of lidocaine per guideline criteria is only supported for neuropathic pain as a second line agent after first line treatment such as tricyclic antidepressants or agents such as Gabapentin or Lyrica have failed. While this individual is with multiple complaints of body and joint pain, there is no documentation of neuropathic pain based on the claimant's physical examination or imaging. The topical use of this agent is not medically necessary.

**Compounded Ketoprofen 20% in PLO Gel 120 gm:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

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

**Decision rationale:** California MTUS ACOEM Guidelines would not support the topical use of Ketoprofen. Ketoprofen is a non-FDA approved agent in the topical setting due to high incidence of photosensitivity dermatitis. The use Ketoprofen in this individual is not medically necessary.

**Compounded Cyclophene 5% in PLO Gel 120 Grams:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

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

**Decision rationale:** California MTUS ACOEM Guidelines would not support the topical use of Cyclophene. The use of this topical muscle relaxant would not be indicated. Guidelines in regards to the use of muscle relaxants in a topical setting indicate that there is no evidence of in literature for benefit or support. The specific use of this agent is not medically necessary.

**Synapryn (10 mg/1ml) Oral Suspension 500 ml: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78, 93-94.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory Drugs Page(s): 67.

**Decision rationale:** California MTUS ACOEM Guidelines would not support the continued use of Synapryn. Synapryn would not be indicated for anti-inflammatory purposes. This individual is with history of usage of this agent with no documentation of significant benefit or advancement of pain related complaints. In regards to anti-inflammatory agents, they should be utilized for the lowest dose possible in the shortest amount of time possible. There would currently be no indication for continuation of its use. Therefore, the request is not medically necessary.

**Tabradol 1mg/1ml Oral Suspension 250ml: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 41, 64.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram) Page(s): 91-94.

**Decision rationale:** Guidelines would not support the continued use of Tabradol. California MTUS ACOEM Chronic Pain Medical Treatment Guidelines do not support the use of Tramadol or related products in the oral setting for greater than 16 weeks due to lack of long term efficacy. This individual has been utilizing this agent for greater than a 16-week period of time. Its continued use based on the claimant's clinical presentation is not medically necessary.

**Deprizine 15mg/ml Oral Suspension 250ml: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms & Cardiovascular Risk Page(s): 68-69.

**Decision rationale:** California MTUS ACOEM Chronic Pain Medical Treatment Guidelines do not support the continued use of Deprizine. Deprizine, a protective gastrointestinal (GI) agent, would not be indicated, as there is no current indication of significant GI risk factor in this individual. Without documentation of significant risk factor or significant use of nonsteroidal

agents, which have also not been supported, the continued use of this oral agent is not medically necessary.

**Dicopanel 5mg/ml Oral Suspension 150ml: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - Treatment in Worker's Comp (TWC), 18th Edition, 2013 Updates: Pain Procedure, Insomnia treatment.

**Decision rationale:** California MTUS ACOEM Guidelines are silent. Currently, Official Disability Guidelines would not support Dicopanol or any other insomnia agent as there is no current diagnosis of insomnia or clinical indication for treatment of insomnia. The use of this agent is not medically necessary.

**Fantrex (Gabapentin) 25mg/ml Oral Suspension: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-22.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs) Page(s): 18.

**Decision rationale:** California MTUS ACOEM Guidelines would not support the continued use of Fanatrex. This brand name form of Gabapentin would not be indicated as there is currently no indication of a neuropathic diagnosis, physical examination or imaging consistent with neuropathic diagnosis or indication for treatment. The use of this neuropathic agent is not medically necessary.