

<b>Case Number:</b>	CM14-0000107		
<b>Date Assigned:</b>	01/10/2014	<b>Date of Injury:</b>	11/21/2011
<b>Decision Date:</b>	04/30/2014	<b>UR Denial Date:</b>	12/24/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/31/2013

### 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 Physical Medicine & Rehabilitation and is licensed to practice in Illinois. 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 47-year-old male who reported an injury on 12/21/2011. The mechanism of injury was not provided for review. The patient reportedly sustained a full thickness rotator cuff tear while performing normal job duties. The patient's treatment history included physical therapy, acupuncture, medications, shockwave therapy, and a home exercise program. The patient underwent surgical intervention in 12/2012, followed by a course of postoperative treatment. The patient's most recent clinical evaluation documented the patient had persistent pain complaints rated at a 5/10. Physical findings included decreased range of motion and decreased motor strength rated at a 4/5. The patient's diagnoses included status post shoulder rotator cuff repair. The patient's treatment plan included topical analgesics, Depriazine, Dicoprofanol, Fanatrex, Synapryn and Tabradol.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**COMPOUNDED KETOPROFEN 20% 120G:** Upheld

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

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

**Decision rationale:** The clinical documentation submitted for review does indicate that the patient has persistent pain complaints that would benefit from medication usage. However, the California Medical Treatment Utilization Schedule does not support the use of ketoprofen in a topical analgesic as it is not FDA-approved to treat symptoms in a topical formulation. The clinical documentation does not provide any exceptional factors to support extending treatment beyond guideline recommendations. As such, the requested ketoprofen 20% is not medically necessary or appropriate.

**COMPOUNDED CYCLOPHENE 5% 120G: Upheld**

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

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

**Decision rationale:** The clinical documentation submitted for review does indicate that the patient has persistent pain complaints that would benefit from the use of medications. However, the California Medical Treatment Utilization Schedule does not support the use of cyclobenzaprine as a topical analgesic, as there is little scientific evidence to support the efficacy and safety of muscle relaxants in a topical formulation. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. As such, the requested Cyclophene 5% 120 gm is not medically necessary or appropriate.

**SYNAPRYN 10MG/ML, 250 ML: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation [www.dailymed.nlm.nih.gov](http://www.dailymed.nlm.nih.gov)

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

**Decision rationale:** The requested medication is a liquid formulation that contains glucosamine. The California Medical Treatment Utilization Schedule does recommend the use of glucosamine in the management of pain related to osteoarthritis. The clinical documentation submitted for review does not provide any evidence that the patient has osteoarthritis of the shoulder. Therefore, it is unclear how the use of this medication would benefit the patient. Additionally, the clinical documentation does not provide any evidence that the patient requires an oral liquid formulation of this medication. As such, the requested Synapryn 10 mg/1 mL 250 mL is not medically necessary or appropriate.

**TABRADOL 1MG/ML, 250ML: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation [www.dailymed.nlm.nih.gov](http://www.dailymed.nlm.nih.gov)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Ongoing Management Page(s): 78.

**Decision rationale:** The requested medication is a compounded liquid formulation that contains tramadol. The California Medical Treatment Utilization Schedule recommends the ongoing use of opioids in the management of chronic pain be supported by a quantitative assessment of pain relief, documentation of functional benefit, evidence that the patient is monitored for aberrant behavior, and managed side effects. The clinical documentation submitted for review does not provide any evidence of a quantitative assessment of pain relief, managed side effects, functional benefit, or that the patient is monitored for aberrant behavior. Additionally, the clinical documentation does not provide any support for the need for a liquid formulation of this medication. As such, the requested Tabradol 1 mg / mL 250 mL is not medically necessary or appropriate.

**DEPRIZINE 15MG/ML, 250ML:** 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 NSAIDs, GI symptoms Page(s): 68.

**Decision rationale:** This medication is considered a gastrointestinal protectant. The California Medical Treatment Utilization Schedule recommends gastrointestinal protectants for patients who are at risk for developing gastrointestinal events related to medication usage. The clinical documentation submitted for review does not provide an adequate assessment of the patient's gastrointestinal system to support that they are at risk for developing disturbances related to medication usage. Additionally, the clinical documentation does not provide any support for the need for a liquid formulation of this medication. As such, the requested Deprizine 15 mg / mL 250 mL is not medically necessary or appropriate.

**DICOPANOL 5MG/ML, 420ML:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation [www.ncbi.nlm.nih.gov](http://www.ncbi.nlm.nih.gov)

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

**Decision rationale:** This is a liquid formulation of an antihistamine. The California Medical Treatment Utilization Schedule does not recommend insomnia treatments. The Official Disability Guidelines do not recommend long-term use of sedative antihistamines in the management of insomnia related to chronic pain. The clinical documentation submitted for review does not provide an adequate assessment of the patient's sleep hygiene that would support the need for pharmacological interventions. There is no documentation that the patient has failed

to respond to nonpharmacological interventions. Additionally, there is no objective documentation of the patient's sleep hygiene to support the need for this medication. Also, there is no documentation to support the need for this medication in a liquid formulation. As such, the requested Dicopan<sup>ol</sup> (Diphen<sup>dr</sup>amine) 5 mg / mL 420 mL is not medically necessary or appropriate.