

Case Number:	CM14-0090184		
Date Assigned:	08/08/2014	Date of Injury:	12/03/2012
Decision Date:	09/26/2014	UR Denial Date:	05/22/2014
Priority:	Standard	Application Received:	06/16/2014

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 Anesthesiology, has a subspecialty in Pain Management, and is licensed to practice in Tennessee. 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:

This is a 26 year old female with a 12/3/2012 date of injury. The exact mechanism of the original injury was not clearly described. A progress reported dated 4/18/14 noted subjective complaints of 8/10 low back pain radiating to the left leg . Objective findings included decreased lumbar ROM, tenderness of the paraspinals, positive left straight leg raise, and minimal left lower extremity weakness diffusely. Reflexes were symmetric and 2+ bilateral lower extremities. A 4/4/14 report noted decreased sensation in the left L4 dermatome and diminished strength 4/5 of the left big toe extensors. A lumbar MRI 1/18/13 noted L4-L5 four mm right paracentral sub ligamentous extruded disc herniation with a tear in the inferior annular fibers with minimal flattening of the right paramedian ventral thecal sac, and L5-S1 four mm right paracentral disc protrusion attenuating the anterior epidural fat. 4/26/13 NCV was normal. EMG demonstrated left active L4 radiculopathy. Diagnostic Impression: L4-L5 extruded disc, L4 radiculopathy Treatment to Date: acupuncture, ESI, medication management A UR decision dated 5/21/14 denied the request for therabenzaprine-60. Until there are higher quality studies of the ingredients in Theramine, it remains not recommended. There is no guideline support for the use of cyclobenzaprine as there has not been a documented acute exacerbation of pain. It also denied a request for medrox patches. This medication contains capsaicin which is recommended only as an option in patients who have not responded or are intolerant to other treatments. It also denied a request for flurbiprofen 20%/Tramadol 20% in Mediderm base. The guidelines do not address the use of tramadol in a topical formulation. It also denied a request for gabapentin 10%/dextromethorphan 10%/amitryptiline 10% in Mediderm base. It is not clear that neuropathic pain medications have been trialed and failed in an oral formulation. The guidelines do not support the use of gabapentin in a topical formulation. It also denied a request for EMG/NCV of the bilateral lower extremities. Prior MRI and physical exam demonstrate an

established radiculopathy. There has been no change in symptoms or examination to suggest new pathology that would warrant a repeat EMG/NCV. It also denied a request for MRI of the lumbar spine, without contrast. The patient has had a prior MRI just over one year ago. There has been no note of significant change.

IMR ISSUES, DECISIONS AND RATIONALES

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

Therabenzaprine-60 (Theramine, 60 tablets co-packaged with Cyclobenzaprine 10 mg, 60 tablets): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (For Pain). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Pain Chapter, Medical Food, Theramine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 41-42. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter.

Decision rationale: The Official Disability Guidelines state that Theramine is not recommended. Theramine is a medical food from [REDACTED], [REDACTED], that is a proprietary blend of gamma-aminobutyric acid [GABA] and choline bitartrate, L-arginine, and L-serine. It is intended for use in the management of pain syndromes that include acute pain, chronic pain, fibromyalgia, neuropathic pain, and inflammatory pain. There is no high quality peer-reviewed literature that suggests that GABA is indicated; there is no known medical need for choline supplementation; L-Arginine is not indicated in current references for pain or inflammation; and L-Serine is not indicated. In a manufacturer study comparing Theramine to naproxen, Theramine appeared to be effective in relieving back pain without causing any significant side effects. Until there are higher quality studies of the ingredients in Theramine, it remains not recommended. According to page 41 of the California MTUS Chronic Pain Medical Treatment Guidelines, Cyclobenzaprine is recommended as an option, using a short course of therapy. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. Treatment should be brief. There is also a post-op use. The addition of cyclobenzaprine to other agents is not recommended. However, there is no documentation of the intended frequency or duration of treatment with cyclobenzaprine. With a 2012 date of injury and no documentation of acute exacerbation of low back pain or change in condition, it is unclear why muscle relaxants would be needed at this time. Therefore, the request was not medically necessary.

Medrox Patches, QTY: 1 month supply: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation DailyMed <http://dailymed.nlm.nih.gov/dailymed/archives/fdaDrugInfo.cfm?archiveid=55285>.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or

Medical Evidence: (<http://www.dailymedplus.com/monograph/view/setid/a9343d24-8435-4a51-98a2-b7976cd369ab>).

Decision rationale: A search of online resources identified Medrox Patches to contain 0.0375% Capsaicin, 5% Menthol, and 5% Methyl Salicylate. The California MTUS Chronic Pain Medical Treatment Guidelines state that ketoprofen, lidocaine (in creams, lotion or gels), capsaicin in a 0.0375% formulation, baclofen and other muscle relaxants, and gabapentin and other antiepilepsy drugs are not recommended for topical applications. The MTUS Chronic Pain Medical Treatment Guidelines does not accept capsaicin at a concentration greater than 0.025%. There is no clear rationale for using this medication as opposed to supported alternatives. Therefore, the request was not medically necessary.

Flurbiprofen 20%/Tramadol 20% in Mediderm base: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Compounded.

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. This compound contains topical Flurbiprofen, which is not currently supported by MTUS guidelines. Also, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. However, there is no mention in the provided documentation that the patient has failed a trial of oral antidepressants or anticonvulsants. Additionally, the requested medication contains topical flurbiprofen, which is not recommended. The guidelines do not specifically address topical tramadol. However, any compound product that contains one drug that is not recommended is not recommended. Therefore, the request was not medically necessary.

Gabapentin 10%/Dextromethorphan 10%/Amitriptyline 10% in Mediderm base: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Compounded.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 25,28,111-113.

Decision rationale: Chronic Pain Medical Treatment Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. CA MTUS Chronic Pain Medical Treatment Guidelines state that ketoprofen, lidocaine (in creams, lotion or gels), capsaicin in anything greater than a 0.025% formulation, baclofen, Boswellia Serrata Resin, and other muscle relaxants, and gabapentin and other

antiepilepsy drugs are not recommended for topical applications. In addition, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. There is no mention that the patient has a failed a trial of oral antidepressants or anticonvulsants. The requested medication contains topical gabapentin, which is not recommended. Any compound product that contains at least one drug that is not recommended is not recommended. Therefore, the request was not medically necessary.

EMG (Electromyography) study of the left lower extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Low Back Chapter, EMG (Electromyography).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back chapter EMG/NCV.

Decision rationale: The California MTUS states that electromyography (EMG), including H-reflex tests, are indicated to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three to four weeks. In addition, the ODG states that EMG may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMGs are not necessary if radiculopathy is already clinically obvious. Furthermore, NCS are not recommended when a patient is presumed to have symptoms on the basis of radiculopathy. However, the patient already has a clinically obvious lumbar radiculopathy based on physical examination in addition to a prior EMG study which confirmed the radiculopathy. There is no mention of interval change. It is unclear why the patient would benefit from repeat electrodiagnostic studies. Therefore, the request was not medically necessary.

EMG (Electromyography) study of the right lower extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Low Back Chapter, EMG (Electromyography).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back chapter EMG/NCV.

Decision rationale: The California MTUS states that electromyography (EMG), including H-reflex tests, are indicated to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three to four weeks. In addition, the ODG states that EMG may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMGs are not necessary if radiculopathy is already clinically obvious. Furthermore, NCS are not recommended when a patient is presumed to have symptoms on the basis of radiculopathy. However, the patient already has a clinically obvious lumbar radiculopathy based on physical examination in addition to a prior EMG study which confirmed the radiculopathy.

There is no mention of interval change. It is unclear why the patient would benefit from repeat electrodiagnostic studies. Therefore, the request was not medically necessary.

NCV (Nerve Conduction Velocity) study of the right lower extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Low Back Chapter, Nerve Conduction Studies (NCS).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back chapter EMG/NCV.

Decision rationale: The California MTUS states that electromyography (EMG), including H-reflex tests, are indicated to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three to four weeks. In addition, the ODG states that EMG may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMGs are not necessary if radiculopathy is already clinically obvious. Furthermore, NCS is not recommended when a patient is presumed to have symptoms on the basis of radiculopathy. However, the patient already has a clinically obvious lumbar radiculopathy based on physical examination in addition to a prior EMG study which confirmed the radiculopathy. There is no mention of interval change. It is unclear why the patient would benefit from repeat electrodiagnostic studies. Therefore, the request was not medically necessary.

NCV (Nerve Conduction Velocity) study of the left lower extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Low Back Chapter, Nerve Conduction Studies (NCS).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back chapter EMG/NCV.

Decision rationale: The California MTUS states that electromyography (EMG), including H-reflex tests, are indicated to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three to four weeks. In addition, the ODG states that EMG may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMGs are not necessary if radiculopathy is already clinically obvious. Furthermore, NCS is not recommended when a patient is presumed to have symptoms on the basis of radiculopathy. However, the patient already has a clinically obvious lumbar radiculopathy based on physical examination in addition to a prior EMG study which confirmed the radiculopathy. There is no mention of interval change. It is unclear why the patient would benefit from repeat electrodiagnostic studies. Therefore, the request was not medically necessary.

MRI (Magnetic Resonance Imaging) of the lumbar spine, without the use of contrast material: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Low Back Chapter, MRI (Magnetic Resonance Imaging).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back chapter MRI.

Decision rationale: The California MTUS supports imaging of the lumbar spine in patients with red flag diagnoses where plain film radiographs are negative; unequivocal objective findings that identify specific nerve compromise on the neurologic examination, failure to respond to treatment, and consideration for surgery. However, the patient already has had a prior lumbar MRI in 1/13. There has not been any documentation of interval change or any new injury. There is no mention in the provided documentation of any plan for surgery. It is unclear why a repeat MRI would be of benefit. Therefore, the request was not medically necessary.