

<b>Case Number:</b>	CM14-0193457		
<b>Date Assigned:</b>	11/20/2014	<b>Date of Injury:</b>	02/03/2007
<b>Decision Date:</b>	01/14/2015	<b>UR Denial Date:</b>	11/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/10/2014

### 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 Physical Medicine & Rehabilitation, has a subspecialty in Interventional Spine 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:

This patient is a 47 year old male with a date of injury of 2/3/07. The listed diagnosis is lumbar spine s/p surgeries x2. Per treating physician report 8/13/14, the patient presents with complaints of low back pain radiating to the left lower extremity with numbness and tingling. The pain is rated as 7/10. Physical examination revealed range of motion with flexion 35, extension 10, right lateral flexion 15, left lateral flexion 15 and positive straight leg raise on the left. There is a tenderness and muscle spasm in the lower back. The treating physician states that the patient's condition has established the need for compounded topical cream. Treatment plan is for refill of medications including Ambien, Methoderm gel, Calypso cream, Theramine and Trepadone and a urine drug screen. The Utilization review letter dated 11/7/14 denied the request. Treatment reports dated 8/13/14 and 5/21/14 were provided for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective theramine (unspecified amount and strength): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111. 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) pain chapter, has the following regarding Theramine

**Decision rationale:** This patient presents with constant low back pain radiating to the left lower extremity with numbness and tingling. The ACOEM and MTUS guidelines do not discuss Theramine, a medical food. ODG guidelines under pain chapter, has the following regarding Theramine, "Not recommended. Theramine is a medical food from Physician Therapeutics, Los Angeles, CA, that is a proprietary blend of gamma-amino butyric acid [GABA] and choline bitartrate, L-arginine, and L-serine. Theramine is not supported by ODG. The requested Theramine is not medically necessary.

**Retrospective Treadone (unspecified amount and strength):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111. 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) pain chapter, Treadone Pain chapter, medical food

**Decision rationale:** This patient presents with constant low back pain radiating to the left lower extremity with numbness and tingling. ODG has the following under its pain section, "Treadone is a medical food from [REDACTED] that is a proprietary blend of L-arginine, L-glutamine, choline bitartrate, L-serine and gammaaminobutyric acid [GABA]. It is intended for use in the management of joint disorders associated with pain and inflammation. Regarding Medical Food, ODG states it "is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements..." In this case, there is no evidence that the patient has deficits of L-arginine, L-glutamate, choline bitartrate, etc., contained in Treadone. The requested Treadone is not medically necessary.

**Retrospective Methoderm gel 120gm:** 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:** Decision based on MTUS Chronic Pain Treatment Guidelines MTUS has the following regarding topical creams (chronic pain )section : Topical Analgesics Pa.

**Decision rationale:** This patient presents with constant low back pain radiating to the left lower extremity with numbness and tingling. Methoderm gel contains menthol and methyl salicylate (NSAID). The MTUS Guidelines, page 111, allow for the use of topical NSAID for peripheral joint arthritis and tendinitis. ODG guidelines support BenGay, which contains similar products as Methoderm. It is recommended for acute and chronic pain conditions, particularly osteoarthritis affecting peripheral joints. In this case, the patient does not meet the indication for

this medication as she suffers from low back pain and not peripheral arthritis. The requested Mentoderm is not medically necessary.