

<b>Case Number:</b>	CM15-0185110		
<b>Date Assigned:</b>	09/29/2015	<b>Date of Injury:</b>	10/29/2013
<b>Decision Date:</b>	11/24/2015	<b>UR Denial Date:</b>	09/01/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/21/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

### 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 57 year old female who sustained a work-related injury on 10-29-13. Medical record documentation on 8-21-15 revealed the injured worker was being treated for right wrist sprain-strain, right hand ring finger trigger finger, right ankle synovitis and right ankle sprain-strain. She reported right wrist and hand pain with numbness, and right ankle pain. She rated her right wrist-hand pain a 5 on a 10-point scale (unchanged since her previous evaluation) and her right ankle pain a 6-7 on a 10-point scale (unchanged since her previous evaluation). Objective findings included grade 2 tenderness to palpation of the right wrist and hand (unchanged since her previous evaluation). She had restricted range of motion of the right wrist. She had grade 2-3 tenderness to palpation of the right ankle (unchanged since her previous evaluation) and had restricted range of motion of the right ankle. She has completed 18 sessions of physical therapy which have helped decrease her pain and tenderness (7-10-15) and was administered an injection of Xylocaine and Depo-Medrol into the right wrist. Medications included Compound cream, Theramine, and Tramadol (all since at least 7-10-15). On 9-1-15, the Utilization Review physician determined physical therapy three times per week for four weeks be modified to physical therapy two times per week for the left wrist and left elbow, and determined EMG-NCV of the bilateral upper extremities, Ultram 50 mg #60 Theramine #90 and Compound Cream: gabapentin 10%, cyclobenzaprine 6% and tramadol 10% was not medically necessary based on CA MTUS Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy for the left wrist and left elbow 3 times a week for 4 weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

**Decision rationale:** California Labor Code Section 4604.5(c) (1) states. During the previous physical therapy sessions, the patient should have been taught exercises which are to be continued at home as directed by MTUS. The patient has completed 18 sessions of physical therapy to date. 12 additional visits will exceed the limit set by the guidelines. The original reviewer modified the request to 2 sessions to comply with the MTUS Guidelines. Physical therapy for the left wrist and left elbow 3 times a week for 4 weeks is not medically necessary.

**EMG (Electromyography)/ NCV (Nerve Conduction Velocity) study of bilateral upper extremities: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM (American College of Occupational and Environmental Medicine) Web -based version: Neck and Upper Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies.

**Decision rationale:** The MTUS states that electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. Detailed evidence of severe and/or progressive neurological abnormalities has not been documented. Evidence of a recent comprehensive conservative treatment protocol trial and failure has not been submitted. EMG (Electromyography)/ NCV (Nerve Conduction Velocity) study of bilateral upper extremities is not medically necessary.

**Ultram 50mg # 60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. Ultram is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic. Despite the long-term use of Ultram, the patient has reported very little, if any, functional improvement or pain relief over the course of the last 6 months. Ultram 50mg # 60 is not medically necessary.

**Theramine #90: 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) Treatment in Workers Compensation (TWC).

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

**Decision rationale:** Theramine is a Food and Drug Administration regulated medical food designed to address the increased nutritional requirements associated with chronic pain syndromes and low back pain. Theramine is thought to promote the production of the neurotransmitters that help manage and improve the sensory response to pain and inflammation. Medical food is defined in section 5(b) of the Orphan Drug Act (21 U.s.c.360ee (b) (3)) as a food which is formulated to be consumed or administered enterally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation. Medical foods do not have to be registered with the FDA and as such are not typically subject to the rigorous scrutiny necessary to allow recommendation by evidence-based guidelines. Theramine #90 is not medically necessary.

**Compound cream Gabapentin 10%, Cyclobenzaprine 6%, Tramadol 10%: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** According to the MTUS, there is little to no research to support the use of many of these compounded topical analgesics. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Gabapentin is not recommended. There is no peer-reviewed literature to support use. Compound cream Gabapentin 10%, Cyclobenzaprine 6%, Tramadol 10% is not medically necessary.