

<b>Case Number:</b>	CM15-0188833		
<b>Date Assigned:</b>	09/30/2015	<b>Date of Injury:</b>	07/13/2005
<b>Decision Date:</b>	12/10/2015	<b>UR Denial Date:</b>	09/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/25/2015

### 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: Tennessee, Florida, Ohio  
 Certification(s)/Specialty: Surgery, Surgical Critical Care

### 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 injured worker is a 52 year old male who sustained an industrial injury on 7-13-05. The diagnosis is noted as lumbar radiculopathy. Previous treatment includes Morphine pump implant 10-13-10, disectomy 8-3-05, laminectomy 12-8-07, spinal cord stimulator (unsuccessful trial) 3-18-09, and medications. In an office visit note dated 9-3-15, the physician reports he is seen this visit for a pump refill and programming. Complaints are of left radicular symptoms. He notes increased tingling, more left than right, in the leg and achy pain and numbness. Pain is rated at 5 out of 10 and notes that he awakens at night due to back pain (7-24-15 pain rated 5 out of 10). He reports he had been more active; vacuuming the car, camping, and was able to walk the mall. It is noted that the muscle relaxant helps reduce his chronic muscle spasms that are in the low back and around the pain pump and that the combination of the medications and Morphine pump allow him to walk for longer distances and bend without excruciating pain. It is noted there is no aberrant behavior or adverse events and pain is decreased with the medications. Physical exam reveals he walks with a limp, there is bilateral tenderness and spasms of L3-5 paraspinal muscles, decreased lumbar range of motion, numbness in medial distribution of both hands and decreased sensory to pinprick along the left lateral leg and thigh. It is reported that he has permanent work restrictions and has not worked since 2005. It is noted that his current regime is controlling symptoms so he can continue to take care of his wife and that perhaps he is having more radicular pain as he is not getting the Cymbalta. The plan is for refill of Butrans, Prilosec, Flexeril, Docuprene, Lidocaine Patches, Flurbiprofen Cream- and with oral non-steroidal anti-inflammatory drugs he was getting gastritis so he tries to take as little of those as possible. A request for authorization is dated 9-8-15. The requested treatment of Flexeril 7.5mg#30, Lidocaine Patches #30, Theramine #90, Flurbiprofen Cream was non certified on 9-14-15.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **30 Flexeril 7.5 mg:** 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): Cyclobenzaprine (Flexeril).

**Decision rationale:** There is not sufficient clinical information provided to justify the medical necessity of this prescription for this patient. In accordance with the California MTUS guidelines, Cyclobenzaprine is a muscle relaxant and muscle relaxants are not recommended for the treatment of chronic pain. Guidelines recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic back pain. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. This patient has been diagnosed with chronic back pain and radiculopathy of the lumbar spine. Per MTUS, the use of a muscle relaxant is not indicated. Therefore, based on the submitted medical documentation, the request for Cyclobenzaprine is not-medically necessary.

### **30 Lidocaine patches:** 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): Lidoderm (lidocaine patch).

**Decision rationale:** There is not sufficient clinical information provided to justify the medical necessity of a Lidoderm patch prescription. In accordance with California Chronic Pain MTUS guidelines, Lidoderm (topical Lidocaine) may be recommended for localized peripheral pain after there has been a trial of a first-line treatment. The MTUS guideline specifies tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica as first line treatments. The provided documentation does not show that this patient was tried and failed on any of these recommended first line treatments. Topical Lidoderm is not considered a first line treatment and is currently only FDA approved for the treatment of post-herpetic neuralgia. Therefore, based on the submitted medical documentation, the request for Lidoderm patch prescription is not medically necessary.

### **90 Theramine:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic): Theramine.

**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, medical foods; Theramine.

**Decision rationale:** There is not sufficient clinical information provided to justify the medical necessity of this medication for this patient. The California MTUS guidelines and the ACOEM Guidelines do not address this topic. According to the Official Disability Guidelines (ODG), Theramine is not recommended for the treatment of chronic pain. Theramine is a medical food that contains 5-hydroxytryptophan 95%, choline bitartrate, L-arginine, histidine, L-glutamine, L-serine, gamma-aminobutyric acid (GABA), whey protein concentrates, grape seed extract 85%, cinnamon, and cocoa (theobromine 6%). This patient has chronic lower back pain secondary to an industrial accident. Per ODG, teramine is specifically not indicated for the treatment of chronic pain. Therefore, based on the submitted medical documentation, the request for theramine is not medically necessary.

**Flurbiprofen cream:** 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:** There is not sufficient clinical information provided to justify the medical necessity of this medication for this patient. Per the California MTUS guidelines, topical NSAIDS are only recommended for osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment. They should only be use for Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDS for treatment of osteoarthritis of the spine, hip or shoulder. Use for neuropathic pain is not recommended as there is no evidence to support use. This patient has been documented to chronic back pain secondary to his industrial accident. He has no evidence of osteoarthritis or tendinitis, particularly of the knee or elbow. Per MTUS, topical NSAID application is not warranted for this indication. Therefore, based on the submitted medical documentation, the request for flurbiprofen cream is not medically necessary.