

<b>Case Number:</b>	CM15-0094265		
<b>Date Assigned:</b>	05/20/2015	<b>Date of Injury:</b>	09/13/2011
<b>Decision Date:</b>	07/02/2015	<b>UR Denial Date:</b>	05/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/15/2015

### 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: Physical Medicine & Rehabilitation

### 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 54 year old female who sustained a work related injury September 13, 2011. According to a primary treating physician's progress report, dated March 16, 2015, the injured worker presented for pain management and follow-up evaluation. She continues to experience constant low back pain radiating distally down the left lower extremity with numbness and tingling down the left leg, rated 7/10. There is tenderness to palpation along the lumbar spine. Straight leg raise is positive on the left and negative on the right. There is decreased sensation to light touch along the L5-S1 nerve root distribution over the left lower extremity. Diagnoses are lumbar radiculopathy and lumbar facet syndrome. Treatment plan included the administration of vitamin B12 intramuscularly into gluteus muscle and instruction to continue home exercises. At issue, is the request for authorization for B12 injection, lumbar spine brace, Genicin, and Terocin.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Genicin #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine (and Chondroitin Sulfate). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back, Lumbar & Thoracic (Acute & Chronic): Glucosamine.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine (and Chondroitin Sulfate) Medications for chronic pain Page(s): 50, 60.

**Decision rationale:** The patient presents with low back pain radiating to lower extremity rated 7/10. The request is for Genicin #90. The request for authorization is dated 05/13/15. Physical examination of the lumbar spine reveals tenderness to palpation along the lumbar spine. Straight leg raise is positive on the left and negative on the right. There is decreased sensation to light touch along the L5 to S1 nerve root distribution over the left lower extremity. Patient's medications include Ambien, Omeprazole, Cyclobenzaprine, Terocin, Flurbi (NAP) Cream, Gabacyclotram, Genicin, Somnicin, Theramine and Trepadone. Per progress report dated 04/20/15, the patient is temporarily totally disabled. MTUS Chronic Pain Medical Treatment Guidelines, page 50 under Glucosamine (and Chondroitin Sulfate) states: Recommended as an option given its low risk, in patients with moderate arthritis pain, especially for knee osteoarthritis. Studies have demonstrated a highly significant efficacy for crystalline glucosamine sulphate (GS) on all outcomes, including joint space narrowing, pain, mobility, safety, and response to treatment, but similar studies are lacking for glucosamine hydrochloride (GH). Per progress report dated 04/20/15, treater's reason for the request is "for the treatment of arthritic pain." The patient has been prescribed Genicin since at least 03/18/15. MTUS supports the use of Glucosamine in patients with moderate arthritis pain. However, the treater does not document efficacy in terms of reduction in pain and improvement in function, as required by MTUS page 60 for all chronic pain medications. Therefore, the request is not medically necessary.

**Terocin 240ml:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines topical lidocaine topical analgesic Page(s): 56-57, 112. Decision based on Non-MTUS Citation Official disability guidelines Pain chapter, Lidoderm patches.

**Decision rationale:** The patient presents with low back pain radiating to lower extremity rated 7/10. The request is for Terocin 240ML. The request for authorization is dated 05/13/15. Physical examination of the lumbar spine reveals tenderness to palpation along the lumbar spine. Straight leg raise is positive on the left and negative on the right. There is decreased sensation to light touch along the L5 to S1 nerve root distribution over the left lower extremity. Patient's medications include Ambien, Omeprazole, Cyclobenzaprine, Terocin, Flurbi (NAP) Cream, Gabacyclotram, Genicin, Somnicin, Theramine and Trepadone. Per progress report dated 04/20/15, the patient is temporarily totally disabled. Terocin patches are dermal patches with Capsaicin 0.025%-Methyl Salicylate 25%-Menthol 10%-Lidocaine 2.5%. MTUS Guidelines page 57 states, topical Lidocaine may be recommended for localized peripheral pain after there

has been evidence of a trial of first-line treatment (tricyclic or SNRI antidepressants or an AED such as Gabapentin or Lyrica). Page 112 also states, Lidocaine indicates: Neuropathic pain. Recommended for localized peripheral pain. In reading ODG Guidelines, it specifies that Lidoderm patches are indicated as a trial if there is evidence of localized pain that is consistent with a neuropathic etiology. ODG further requires documentation of the area for treatment, trial of a short-term use, and outcome documented for function and pain. Treater does not specifically discuss this medication. In this case, the patient does not present with localized peripheral pain, for which Terocin patch would be indicated. Patient has been prescribed Terocin patches since at least 12/04/14. MTUS requires recording of pain and function when medications are used for chronic pain (p60). Given the lack of specific discussion regarding this topical product, it cannot be assumed that it has resulted in pain reduction and functional improvement, otherwise unachieved without this product. Therefore, the request is not medically necessary.

### **1 lumbar spine brace: 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), Low back, Lumbar & Thoracic (Acute & Chronic) - Lumbar supports.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official disability guidelines Low Back, Lumbar & Thoracic Chapter, lumbar supports.

**Decision rationale:** The patient presents with low back pain radiating to lower extremity rated 7/10. The request is for 1 lumbar spine brace. The request for authorization is dated 05/13/15. Physical examination of the lumbar spine reveals tenderness to palpation along the lumbar spine. Straight leg raise is positive on the left and negative on the right. There is decreased sensation to light touch along the L5 to S1 nerve root distribution over the left lower extremity. Patient's medications include Ambien, Omeprazole, Cyclobenzaprine, Terocin, Flurbi (NAP) Cream, Gabacyclotram, Genicin, Somnicin, Theramine and Trepadone. Per progress report dated 04/20/15, the patient is temporarily totally disabled. ACOEM Guidelines page 301 on lumbar bracing states, lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. ACOEM guidelines further state that they are not recommended for treatment, but possibly used for prevention if the patient is working. ODG Low Back Lumbar & Thoracic Chapter, lumbar supports topic, states, Recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP (very low-quality evidence, but may be a conservative option). For post-operative bracing, ODG states, "Under study, but given the lack of evidence supporting the use of these devices, a standard brace would be preferred over a custom post-op brace, if any, depending on the experience and expertise of the treating physician." Treater does not discuss the request. In this case, guidelines recommend lumbar bracing only for the acute phase of symptom relief, compression fractures, treatment of spondylolisthesis and documented instability. No evidence of aforementioned conditions is provided for this patient. There is no evidence of recent back surgery, either. For non-specific low back pain, there is very low quality evidence, and ACOEM guidelines do not support the use of a back brace for chronic pain. Therefore, the request is not medically necessary.

## **1 B12 injection: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National guidelines clearinghouse - Medical services commission. Cobalamin (Vitamin B12) deficiency-Investigation and management. Victoria (BC): British columbia medical services commission; 2012 Jan 1. 5p. (16 references).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Pain Chapter, Vitamin B.

**Decision rationale:** The patient presents with low back pain radiating to lower extremity rated 7/10. The request is for 1 B12 injection. The request for authorization is dated 05/13/15. Physical examination of the lumbar spine reveals tenderness to palpation along the lumbar spine. Straight leg raise is positive on the left and negative on the right. There is decreased sensation to light touch along the L5 to S1 nerve root distribution over the left lower extremity. Patient's medications include Ambien, Omeprazole, Cyclobenzaprine, Terocin, Flurbi (NAP) Cream, Gabacyclotram, Genicin, Somnicin, Theramine and Trepadone. Per progress report dated 04/20/15, the patient is temporarily totally disabled. ODG, Pain Chapter, under Vitamin B states, Not recommended for treatment of chronic pain. Vitamin B is frequently used for treating peripheral neuropathy, but its efficacy is not clear. ODG under the pain chapter further discusses B vitamins and vitamin B complex and states, not recommended for treatment of chronic pain unless this is associated with documented vitamin deficiency. Treater does not discuss the request. Patient has received two prior B12 injections on 12/04/14 and 04/20/15. However, treater does not provide any discussion as to why the patient needs B12 injections. There is no indication that this patient has a vitamin deficiency and ODG states that Vitamin B is not recommended for chronic pain. Therefore, the request is not medically necessary.