

<b>Case Number:</b>	CM14-0086320		
<b>Date Assigned:</b>	07/23/2014	<b>Date of Injury:</b>	03/17/2014
<b>Decision Date:</b>	09/17/2014	<b>UR Denial Date:</b>	06/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/09/2014

### 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 Occupational Medicine 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:

Patient is a 32-year-old female who has submitted a claim for thoracic or lumbosacral radiculitis and sprain/strain of lumbar region associated with an industrial injury date of 3/17/2014. Medical records from 2014 were reviewed. The patient complained of back pain described as burning sensation. Physical exam showed tenderness over the paralumbar muscles and thoracic region. Sensation was diminished at the left L5 dermatome. Electromyogram of bilateral lower extremities, dated 6/17/2014, revealed acute and chronic lumbosacral radiculopathy primarily involving L5 not excluding S1. NCV study was normal. Treatment to date has included physical therapy, activity restrictions, and topical medications. Utilization review from 6/2/2014 modified the request for Chiropractic two (2) times a week for four (4) weeks for Thoracic Spine into 2 x 3 visits as initial trial per guideline recommendation; denied Flurbiprofen/Capsaicin/Menthol/Camphor, 120 gm and Ketoprofen/Cyclobenzaprine/Lidocaine, 120 gm because of limited published studies concerning its efficacy and safety; denied Ortho shockwave for Lumbar Spine because the available evidence did not support the effectiveness of ultrasound or shockwave for treating low back pain; and denied urine toxicology screen because the patient was not on opioids and there was no plan to initiate such treatment.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Chiropractic two (2) times a week for four (4) weeks for Thoracic Spine: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26, Manipulation Therapy Page(s): 58-59.

**Decision rationale:** As stated on pages 58-59 of CA MTUS Chronic Pain Medical Treatment Guidelines, several studies of manipulation have looked at duration of treatment, and they generally showed measured improvement within the first few weeks or 3-6 visits of chiropractic treatment, although improvement tapered off after the initial sessions. There should be some outward sign of subjective or objective improvement within the first 6 visits for continuing treatment. In this case, the patient presented with back pain described as a burning sensation; hence, this request for chiropractic care. However, there was no comprehensive physical examination available to support such treatment. Moreover, the request exceeded guideline recommendation of initial 3 to 6 visits to assess functional response prior to extension of services. Therefore, the request for Chiropractic two (2) times a week for four (4) weeks for Thoracic Spine is not medically necessary.

**Flurbiprofen/Capsaicin/Menthol/Camphor, 120 gm: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Non-steroidal anti-inflammatory agents (NSAIDs), Capsaicin, Flurbiprofen. Decision based on Non-MTUS Citation Drugs.com updated April 15th, 2013 - Menthol Topical Dosage <http://www.drugs.com/dosage/menthol-topical.html> - Usual Adult Dose for Pain.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CAPSAICIN; TOPICAL ANALGESICS Page(s): 28-29; 111-113.

**Decision rationale:** As stated on pages 111-113 of the California MTUS Chronic Pain Medical Treatment Guidelines, topical analgesics are largely experimental in use with few randomized controlled trials to determine safety or efficacy. In addition, there is little to no research as for the use of flurbiprofen in compounded products. CA MTUS Chronic Pain Medical Treatment Guidelines identifies on page 28 that topical Capsaicin is only recommended as an option if there was failure to respond or intolerance to other treatments. The guideline states there is no current indication that an increase over a 0.025% formulation of capsaicin would provide any further efficacy. Regarding the Menthol component, CA MTUS does not cite specific provisions, but the ODG Pain Chapter states that the FDA has issued an alert in 2012 indicating that topical OTC pain relievers that contain menthol, methyl salicylate, or capsaicin, may in rare instances cause serious burns. The guidelines do not address camphor. In this case, there is no discussion concerning intolerance or failure to current oral medications to warrant topical products. Moreover, the prescribed medication contains Flurbiprofen, which is not recommended for topical use. Guidelines state that any compounded product that contains a drug class that is not recommended is not recommended. Therefore, the request for Flurbiprofen/Capsaicin/Menthol/Camphor, 120 gm is not medically necessary.

**Ketoprofen/Cyclobenzaprine/Lidocaine, 120 gm: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antispasmodics, Cyclobenzaprine, Lidocaine Indication.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111-113.

**Decision rationale:** As stated on pages 111-113 of the California MTUS Chronic Pain Medical Treatment Guidelines, topical analgesics are largely experimental in use with few randomized controlled trials to determine safety or efficacy. Ketoprofen is not recommended for topical use as there is a high incidence of photo contact dermatitis. Cyclobenzaprine is not recommended for use as a topical analgesic. Topical formulations of lidocaine (whether creams, lotions or gels) are not indicated for neuropathic or non-neuropathic pain complaints. In this case, there is no discussion concerning intolerance or failure to current oral medications to warrant topical products. Moreover, the prescribed medication contains ketoprofen, cyclobenzaprine, and lidocaine, which are not recommended for topical use. Guidelines state that any compounded product that contains a drug class that is not recommended is not recommended. Therefore, the request for Ketoprofen/Cyclobenzaprine/Lidocaine, 120 gm is not medically necessary.

**Ortho shockwave for Lumbar Spine:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic): Shock wave therapy.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Shockwave Therapy.

**Decision rationale:** The CA MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, the Official Disability Guidelines (ODG), was used instead. ODG states that, Shockwave Therapy is not recommended. The available evidence does not support the effectiveness of ultrasound or shock wave for treating LBP. In the absence of such evidence, the clinical use of these forms of treatment is not justified and should be discouraged. In this case, the patient was prescribed Extracorporeal Shockwave Therapy (ESWT). However, records reviewed failed to establish compelling circumstances identifying why ESWT for the low back unit be required despite adverse evidence. There is no documented rationale for this procedure. Therefore, the request for Ortho shockwave for Lumbar Spine is not medically necessary.

**Urine Toxicology Screen:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, ON-GOING MANAGEMENT Page(s): 78.

**Decision rationale:** Page 78 of the CA MTUS Chronic Pain Medical Treatment Guidelines state that urine drug screens are recommended as an option to assess order use or presence of illegal drugs and as ongoing management for continued opioid use. Screening is recommended randomly at least twice and up to 4 times a year. In this case, current medication only includes topical products. No aberrant drug behavior was noted. There is also no plan to initiate opioid therapy, which may warrant urine drug screening. There is no compelling rationale to perform screening at this time. Therefore, the request for urine toxicology screen is not medically necessary.