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| <b>Case Number:</b>   | CM15-0164973 |                              |            |
| <b>Date Assigned:</b> | 09/10/2015   | <b>Date of Injury:</b>       | 04/17/2009 |
| <b>Decision Date:</b> | 10/09/2015   | <b>UR Denial Date:</b>       | 07/24/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 08/21/2015 |

### 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: Illinois, California, Texas  
 Certification(s)/Specialty: Orthopedic Surgery

### 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 injured worker is a 63-year-old male who sustained an industrial injury on 4/17/09. Injury was reported relative to cumulative trauma, and pulling an engine. Conservative treatment included activity modification, medications, physical therapy, TENS unit, ice, chiropractic therapy, muscle stimulator, and injections. The 10/16/13 lumbar spine MRI impression documented a 3-4 mm disc protrusion at L1/2. At L2/3, there was a 5 mm disc protrusion and moderate to severe facet hypertrophy with severe neuroforaminal narrowing and mild central canal stenosis. At L3/4, there was a 6 mm left paracentral disc protrusion causing foraminal narrowing and mild central canal stenosis. At L4/5, there was a 5 mm disc protrusion with facet hypertrophy and moderate to severe bilateral foraminal narrowing. The 10/16/13 lumbar spine x-ray impression documented moderate to severe disc space narrowing and facet hypertrophy at L4/5 and L5/S1. The 10/16/13 bilateral lower extremity electrodiagnostic study evidence suggested possible bilateral L4, L5 and S1 radiculopathy and peripheral neuropathy of the bilateral peroneal nerves. The 6/26/15 treating physician report cited grade 5-6/10 neck and right shoulder discomfort, and grade 6/10 lumbar spine pain radiating to the right lower extremity with numbness and tingling. Pain increased to grade 9-10/10 without medications. Medications included Norco, Naproxen, morphine sulfate, and topical cream, and allowed him to perform his activities of daily living, grocery shopping, and household chores. He continued to use his TENS unit which was helpful for pain control. He complained of difficulty sleeping due to pain and depression, which was currently stable. The treating physician documented that the 10/16/13 neurosurgical consultation report recommended microdecompressive lumbar discectomy for

definitive relief of multilevel herniated disc syndrome. Physical exam documented slow gait, lumbar paraspinal muscle spasms, moderate loss of lumbar range of motion, and positive straight leg raise on the right. The diagnosis included lumbar strain with right radiculopathy and intermittent hypesthesia posterolateral and lateral thigh. The treatment plan included a re-request for lumbar microdiscectomy per the 10/16/13 neurosurgical request. Chiropractic therapy was recommended as it was very helpful for myofascial release. Mentherm topical cream was recommended for continued use as it had helped control chronic pain without pain medications and/or allow the patient to use less pain medication, and it helped with improving activities of daily living. Authorization was requested for lumbar microdiscectomy, compounded medications: Mentherm topical cream (methyl salicylate 15% and menthol 10%), and chiropractic therapy for the lumbar spine 2x3. The 7/24/15 utilization review non-certified the request for lumbar microdiscectomy as there were no clear objective findings of radiculopathy on exam and the specific level to be operated on was not specified. Additionally, this request was based on a neurosurgical recommendation 2 years ago with no indication that the injured worker had been recently evaluated and the recommendation was still current. The request for Mentherm topical cream was non-certified as there was no indication for the necessity of a compound medication at this time. The request for chiropractic therapy for the lumbar spine 2x3 was non-certified as the injured worker appear to be having several chiropractic sessions every few months which appeared to be maintenance care and elective/maintenance care was not medically necessary, and there was no indication of specific functional benefits from the previous sessions completed.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Lumbar Microdiscectomy: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), low back chapter - Decompression.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic: Discectomy/Laminectomy.

**Decision rationale:** The California MTUS recommend surgical consideration when there is severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise. Guidelines require clear clinical, imaging and electrophysiologic evidence of a lesion that has been shown to benefit both in the short-term and long term from surgical repair. The guidelines recommend that clinicians consider referral for psychological screening to improve surgical outcomes. The Official Disability Guidelines recommend criteria for lumbar discectomy that include symptoms/findings that confirm the presence of radiculopathy and correlate with clinical exam and imaging findings. Guideline criteria include evidence of nerve root compression, imaging findings of nerve root compression, lateral disc rupture, or lateral recess stenosis, and completion of comprehensive conservative treatment. Guideline criteria have

not been met. This injured worker presents with low back pain radiating into the right lower extremity with numbness and tingling. Clinical exam findings do not evidence a focal neurologic deficit correlated with imaging evidence of plausible multilevel nerve root compromise. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. This request is predicated on a 10/16/13 neurosurgical report with no specific level of surgical intervention documented. Therefore, this request is not medically necessary at this time.

**Compounded medications: Mentherm topical cream (methyl salicylate 15% and menthol 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:** The California MTUS guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical agents are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. Guidelines state that the efficacy in clinical trials for topical non-steroidal anti-inflammatory drug (NSAIDs) has been inconsistent and most studies are small and of short duration. Guidelines recommend the use of topical NSAIDs for osteoarthritis and tendinitis, particularly of the knee and elbow or other joints that are amenable to topical treatment, limited to 4 to 12 weeks. There is no evidence to recommend a NSAID dosage form other than an oral formulation for low back pain. Guideline criteria have not been met. Records indicated that Mentherm had been prescribed since at least 2/17/14. The continued use of Mentherm topical cream is not supported by guidelines for use in spinal complaints or beyond 12 weeks. There is no compelling rationale to support the use of this topical cream as an exception to guidelines. Therefore, this request is not medically necessary.

**Chiropractic therapy - Lumbar spine 2x3: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004, and Chronic Pain Medical Treatment 2009.

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

**Decision rationale:** The California MTUS guidelines generally support the use of manual therapy and manipulation for the treatment of chronic pain caused by musculoskeletal conditions. MTUS guidelines recommend 1 to 2 chiropractic visits every 4 to 6 months for recurrence/flare-ups of chronic low back pain. Guidelines state that elective/maintenance care is not medically necessary. Guidelines recommend that all therapies be focused on the goal of functional restoration rather than merely the elimination of pain and assessment of treatment

efficacy is accomplished by reporting functional improvement. Functional improvement is defined in the MTUS as either a clinically significant improvement in activities of daily living or a reduction in work restrictions; and a reduction in the dependency on continued medical treatment. Guideline criteria have not been met. This injured worker presents with chronic low back pain radiating into the right lower extremity with numbness and tingling. There is no current evidence of a specific flare-up with associated functional deficit or functional treatment goal to be addressed by chiropractic treatment. Records suggested regular chiropractic treatment with no evidence of maintained functional improvement. There is no compelling reason to support the medical necessity of chiropractic treatment in the absence of a specific function-limiting flare-up, objective maintained functional improvement relative to prior treatment consistent with guidelines, or as an exception to guidelines. Therefore, this request is not medically necessary.