

<b>Case Number:</b>	CM15-0186433		
<b>Date Assigned:</b>	09/28/2015	<b>Date of Injury:</b>	05/05/1999
<b>Decision Date:</b>	11/06/2015	<b>UR Denial Date:</b>	09/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/22/2015

### 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 66 year old male, who sustained an industrial injury on 5-5-1999. Medical records indicate the worker is undergoing treatment for lumbar radiculopathy. A recent progress report dated 8-18-2015, reported the injured worker complained of low back pain rated 4-5 out of 10, radiating to the right lower extremity. He reports slight improvement in symptoms since last visit and attributes it to the use of medications and therapy. Physical examination revealed lumbar tenderness and decreased lower extremity sensation to the right lumbar 4-5 and sacral 1 dermatomes and positive straight leg raise test on the right at 60 degrees. Treatment to date has included acupuncture, 6 visits for chiropractic care, massage therapy, 8 sessions of physical therapy with minimal relief, Effexor, Capsaicin cream and unspecified topical cream. The physician is requesting Additional chiropractic rehabilitative therapy 2 times a week for 4 weeks to the lumbar spine and CM4, Caps 0.05% plus Cyclo4%. On 9-15-2015, the Utilization Review noncertified the request for Additional chiropractic rehabilitative therapy 2 times a week for 4 weeks to the lumbar spine and CM4, Caps 0.05% plus Cyclo4%.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Additional chiropractic rehabilitative therapy 2 times a week for 4 weeks to the lumbar spine:** 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:** The current request is for additional chiropractic rehabilitative therapy 2 times a week for 4 weeks to the lumbar spine. The RFA is dated 08/18/15. Treatment to date has included acupuncture, 6 visits for chiropractic care, massage therapy, 8 sessions of physical therapy, oral medications and topical analgesics. The patient is TTD. MTUS Guidelines, Manual Therapy and Manipulation section, page 40 state: Recommended for chronic pain if caused by musculoskeletal conditions and manipulation is specifically recommended as an option for acute conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in function that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range of-motion but not beyond the anatomic range-of-motion. Treatment Parameters from state guidelines a. Time to produce objective functional gains: 3-5 treatments. b. Frequency: 1-5 supervised treatments per week the first 2 weeks, decreasing to 1-3 times per week for the next 6 weeks, then 1-2 times per week for the next 4 weeks, if necessary. c. Optimum duration: Treatment beyond 3-6 visits should be documented with objective improvement in function. Palliative care should be reevaluated and documented at each treatment session. Per report 08/18/15, the patient presents with chronic lower back pain that radiates to the right lower extremity. He reports slight improvement in symptoms since last visit and attributes it to the use of medications and therapy. The patient is currently receiving massage therapy, and has completed 6 sessions of chiropractic treatments. Physical examination revealed lumbar tenderness and decreased lower extremity sensation to the right lumbar 4-5 and sacral 1 dermatomes and positive straight leg raise test on the right at 60 degrees. The physician is requesting additional chiropractic rehabilitative therapy "as the previous sessions helped to reduce pain." MTUS guidelines indicate that 3-6 sessions of chiropractic therapy are appropriate for conditions of this nature, and that additional sessions are contingent upon functional benefits. In this case, the treater has only provided a generic statement that prior sessions "helped" reduce pain. Without clear documentation of measurable functional improvements attributed to previous chiropractic treatments, the request for additional sessions cannot be supported. The request is not medically necessary.

**CM4, Caps 0.05% plus Cyclo4%:** Upheld

**Claims Administrator guideline:** Decision based on MTUS General Approaches 2004, Section(s): Initial Approaches to Treatment, and Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation [http://www.leginfo.ca.gov/pub/11-12/bill/asm/ab\\_0351-0400\\_ab\\_378\\_bill\\_20110908\\_amended\\_sen\\_v94.html](http://www.leginfo.ca.gov/pub/11-12/bill/asm/ab_0351-0400_ab_378_bill_20110908_amended_sen_v94.html).

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

**Decision rationale:** The current request is for CM4, CAPS 0.05% plus CYCLO4%. The RFA is dated 08/18/15. Treatment to date has included acupuncture, 6 visits for chiropractic care, massage therapy, 8 sessions of physical therapy, oral medications and topical analgesics. The patient is TTD. MTUS Chronic pain guidelines 2009, page 111, Topical Analgesics section states regarding capsaicin, "Recommended only as an option in patients who have not responded or are intolerant to other treatments." Capsaicin is allowed for chronic pain condition such as fibromyalgia, osteoarthritis, and nonspecific low back pain." MTUS, Topical Analgesics, pg. 113: Baclofen: Not recommended. There is currently one Phase III study of Baclofen- Amitriptyline- Ketamine gel in cancer patients for treatment of chemotherapy-induced peripheral neuropathy. There is no peer-reviewed literature to support the use of topical baclofen. Other muscle relaxants: There is no evidence for use of any other muscle relaxant as a topical product. Gabapentin: Not recommended. There is no peer-reviewed literature to support use. Other anti-epilepsy drugs: There is no evidence for use of any other anti-epilepsy drug as a topical product. MTUS Guidelines also states that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Per report 08/18/15, the patient presents with chronic lower back pain that radiates to the right lower extremity. He reports slight improvement in symptoms since last visit and attributes it to the use of medications and therapy. The patient is currently receiving massage therapy, and has completed 6 sessions of chiropractic treatments. Physical examination revealed lumbar tenderness and decreased lower extremity sensation to the right lumbar 4-5 and sacral 1 dermatomes and positive straight leg raise test on the right at 60 degrees. The physician is requesting a topical cream "for his non-specific low back complaints." MTUS page 111 states that if one of the compounded topical product is not recommended, then the entire product is not. In this case, the requested topical compound consists of Cyclobenzaprine which is not indicated for use in topical formulation. Therefore, the requested compounded topical is not medically necessary.