

<b>Case Number:</b>	CM15-0173943		
<b>Date Assigned:</b>	09/15/2015	<b>Date of Injury:</b>	10/05/2011
<b>Decision Date:</b>	11/06/2015	<b>UR Denial Date:</b>	08/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/03/2015

### 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: Emergency Medicine

### 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 63 year old male sustained an industrial injury on 10-5-11. Documentation indicated that the injured worker was receiving treatment for low back pain. Previous treatment included physical therapy, acupuncture, shockwave therapy and medications. In a PR-2 dated 3-6-15, the injured worker complained of burning, radicular low back pain and muscle spasms, rated 4 out of 10 on the visual analog scale, associated with bilateral lower extremity numbness and tingling. Physical exam was remarkable for lumbar spine with tenderness to palpation at the lumbar paraspinal musculature and over the lumbosacral junction, range of motion: flexion 45 degrees, extension and left lateral flexion at 20 degrees, right lateral flexion at 10 degrees and bilateral rotation at 15 degrees, positive bilateral straight leg raise, "slightly" decreased sensation at the L4, L5 and S1 distributions and bilateral lower extremity motor strength 4 out of 5. The injured worker could heel-toe walk with pain and squat to 40% of normal. Toe touch caused low back pain with the fingers at about 4 inches from the ground. In a PR-2 dated 8-17-15, the injured worker complained of burning, radicular low back pain with muscle spasms, rated 8 to 9 out of 10 on the visual analog scale, associated with numbness and tingling of bilateral lower extremities. The injured worker stated that medications offered him temporary relief of pain and improved function and sleep. Past medical history was significant for hypertension and diabetes mellitus. Physical exam was remarkable for lumbar spine with tenderness to palpation at the lumbar paraspinal musculature and over the lumbosacral junction, range of motion: flexion 35 degrees and extension, bilateral lateral flexion and bilateral rotation 15 degrees, positive bilateral straight leg raise, "slightly" decreased sensation at the L4, L5 and S1 distributions and bilateral

lower extremity motor strength 4 out of 5. The injured worker could heel-toe walk with pain and squat to 40% of normal. Toe touch caused low back pain with the fingers at about 4 inches from the ground. The treatment plan included physical therapy three times a week for six weeks, shockwave therapy, referral to a spine specialist and medications (Deprizine, Dicopanol, Fanatrex, Synapryn, Tabradol, Cyclobenzaprine and Ketoprofen cream). On 8-20-15, Utilization Review noncertified a request for six sessions of shockwave therapy for the lumbar spine.

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

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

#### **Shockwave therapy 6 treatments of the 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 (ODG), Low Back, 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 Lumbar & Thoracic (Acute & Chronic)/ Extracorporeal shock wave therapy (ESWT).

**Decision rationale:** The request is for Extracorporeal shock wave therapy (ESWT). The MTUS guidelines have limited information regarding this topic for back pain. The Official Disability Guidelines state the following: 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. (Seco, 2011) In this case, the use of this treatment modality is not indicated. This is secondary to poor clinical evidence regarding effectiveness of use. As such, the request is not medically necessary.

#### **Cyclobenzaprine 5% cream 110 gms: 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 request is for the use of a compounded medication for topical use to aid in pain relief. These products contain multiple ingredients which each have specific properties and mechanisms of action. The MTUS guidelines state the following: "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." In this case, the use of the topical muscle relaxant is not indicated for use for the patient's condition. The MTUS states the following: "There is no evidence for use of any other muscle relaxant as a topical product." As such, the request is not medically necessary.

#### **Ketoprofen 20% cream 167gms: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** The request is for the use of a compounded medication for topical use to aid in pain relief. These products contain multiple ingredients which each have specific properties and mechanisms of action. The MTUS guidelines state the following: "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." In this case, the compounded topical treatment contains an NSAID. Qualifying factors for this product is indicated by the following per the guidelines: The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. (Lin, 2004) (Bjordal, 2007) (Mason, 2004) When investigated specifically for osteoarthritis of the knee, topical NSAIDs have been shown to be superior to placebo for 4 to 12 weeks. Indications: Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: 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. FDA-approved agents: Voltaren Gel 1% (diclofenac): Indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. In this case, as stated above, the patient would not qualify for the use of a topical NSAID. This is based on the diagnosis and treatment duration. As such, the request is not medically necessary.

**Physical therapy 3 times a week for 3 weeks for 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 request is for physical therapy to aid in pain relief. The MTUS guidelines states that manipulation is recommended for chronic pain if caused by musculoskeletal 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 functional improvement 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. It is indicated for low back pain but not ankle and foot conditions, carpal tunnel syndrome, forearm/wrist/hand pain, or knee pain. The use of active treatment modalities instead of passive treatments is associated with substantially better clinical outcomes. (Fritz, 2007) Active treatments also allow for fading of treatment frequency along with active self-directed home PT, so that less visits would be required in uncomplicated cases. In this case, the patient would benefit most from at home active therapy. As such, the request is not medically necessary.

**Acupuncture 3 times a week for 6 weeks for lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Acupuncture Treatment 2007.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods.

**Decision rationale:** The request is for acupuncture to aid in pain relief. The ACOEM guidelines state the following regarding this topic. "Acupuncture has not been found effective in the management of back pain, based on several high-quality studies, but there is anecdotal evidence of its success." In this case the guidelines do not support the use of this treatment modality. This is secondary to the diagnosis with poor clinical evidence regarding efficacy. As such, the request is not medically necessary.