

Case Number:	CM13-0011788		
Date Assigned:	01/03/2014	Date of Injury:	05/06/1989
Decision Date:	03/18/2014	UR Denial Date:	08/05/2013
Priority:	Standard	Application Received:	08/15/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician 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 physician 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:

Claimant is 53 year old female with date of injury 5/6/2013. Initial orthopedic evaluation dated 4/16/2013 reports that claimant stated that on 5/6/1989 she lifted a box and experienced a popping sensation in her low back. She has subsequently had medications, x-rays and MRIs. She has received physical therapy and massage therapy with some benefit. She currently complains of constant, mild to severe, throbbing, sharp, stabbing pain with stiffness in her low back. She reports pain into her buttocks and down her legs into her heels. She denies any numbness, tingling, swelling or discoloration. She confirms locking sensations in her lower back. She notes weakness and giving out of her legs. She confirms loss of bladder control. She denies changes in her bowel. Driving, prolonged sitting, standing or walking, running, abdominal exercises and heavy lifting aggravates her symptoms. The use of medications, soaking in a Jacuzzi, stretching and frequently changing positions affords her some relief. She confirms a regular exercise routine, avoids running, much difficulty with playing tennis and dancing, some difficulty with going to the movies and power walking, and no difficulty with leisurely walks and swimming. Current medications include Vicodin, Etodolac, Naproxen, Ibuprofen, Cyclobenzaprine, Ranitidine, and Citalopram. Exam is notable for positive straight leg raise, but otherwise normal. X-rays of lumbar spine show a severely degenerative L5-S1 disc with severe disc space collapse and facet arthropathy. There is no evidence of spondylolisthesis or spondylosis. Diagnoses include: 1) musculoligamentous sprain/strain, lumbar spine 2) degenerative disc disease L5-S1 with chronic discogenic back pain. Treatment plan includes acupuncture with deep tissue massage, anti-inflammatory medication and a muscle relaxer medication. She is permanent and stationary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Continue Massage Therapy one (1) time a week for Eight (8) weeks, Lumbar: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Massage Therapy section Page(s): 60.

Decision rationale: Per Chronic Pain Medical Treatment Guidelines 8 C.C.R. Â§Â§9792.20 - 9792.26 MTUS (Effective July 18, 2009) massage therapy is "Recommended as an option as indicated below. This treatment should be an adjunct to other recommended treatment (e.g. exercise), and it should be limited to 4-6 visits in most cases. Scientific studies show contradictory results. Furthermore, many studies lack long-term follow-up. Massage is beneficial in attenuating diffuse musculoskeletal symptoms, but beneficial effects were registered only during treatment. Massage is a passive intervention and treatment dependence should be avoided. This lack of long-term benefits could be due to the short treatment period or treatments such as these do not address the underlying causes of pain. (Hasson, 2004) A very small pilot study showed that massage can be at least as effective as standard medical care in chronic pain syndromes. Relative changes are equal, but tend to last longer and to generalize more into psycho logic domains. (Walach 2003) The strongest evidence for benefits of massage is for stress and anxiety reduction, although research for pain control and management of other symptoms, including pain, is promising. The physician should feel comfortable discussing massage therapy with patients and be able to refer patients to a qualified massage therapist as appropriate. (Corbin 2005) Massage is an effective adjunct treatment to relieve acute postoperative pain in patients who had major surgery, according to the results of a randomized controlled trial recently published in the Archives of Surgery. (Mitchinson, 2007)" The claimant has already received massage therapy sessions and physical therapy since her injury. She has a home exercise plan and other modalities to improve her symptoms. Although the claimant reports some benefit from massage therapy, these guidelines only support passive therapy for short periods, and there is no recent acute exacerbation or reinjure that would justify additional massage therapy. The request for Massage Therapy one (1) time a week for Eight (8) weeks, Lumbar is determined to not be medically necessary.

Protonix 20mg #60 x 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms and Cardiovascular Risk section Page(s): 68-69.

Decision rationale: Per Chronic Pain Medical Treatment Guidelines 8 C.C.R. Â§Â§9792.20 - 9792.26 MTUS (Effective July 18, 2009): Clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. Determine if the patient is at risk for

gastrointestinal events: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). Recent studies tend to show that [REDACTED] does not act synergistically with NSAIDs to develop gastroduodenal lesions. Recommendations: Patients at intermediate risk for gastrointestinal events and no cardiovascular disease :(1) A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg omeprazole daily) or misoprostol (200 µg four times daily) or (2) a Cox-2 selective agent. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture (adjusted odds ratio 1.44). The claimant does not have any GI risk factors listed in these guidelines. She is also not taking high doses of NSAIDs that would increase her risk of GI events. The request for Protonix 20mg #60 x 2 refills is determined to not be medically necessary.

Voltaren 100mg #60 x 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-68.

Decision rationale: Back Pain - Acute exacerbations of chronic pain: Recommended as a second-line treatment after acetaminophen. In general, there is conflicting evidence that NSAIDs are more effective than acetaminophen for acute LBP. (van Tulder, 2006) (Hancock, 2007) For patients with acute low back pain with sciatica a recent Cochrane review (including three heterogeneous randomized controlled trials) found no differences in treatment with NSAIDs vs. placebo. In patients with axial low back pain this same review found that NSAIDs were not more effective than acetaminophen for acute low-back pain, and that acetaminophen had fewer side effects. (Roelofs-Cochrane, 2008) The addition of NSAIDs or spinal manipulative therapy does not appear to increase recovery in patients with acute low back pain over that received with acetaminophen treatment and advice from their physician. (Hancock, 2007) Back Pain - Chronic low back pain: Recommended as an option for short-term symptomatic relief. A Cochrane review of the literature on drug relief for low back pain (LBP) suggested that NSAIDs were no more effective than other drugs such as acetaminophen, narcotic analgesics, and muscle relaxants. The review also found that NSAIDs had more adverse effects than placebo and acetaminophen but fewer effects than muscle relaxants and narcotic analgesics. In addition, evidence from the review suggested that no one NSAID, including COX-2 inhibitors, was clearly more effective than another. (Roelofs-Cochrane, 2008) These guidelines do not support the chronic use of NSAID medications, and there is no recent acute exacerbation or reinjury that would justify the use of Voltaren at this time. The request for Voltaren 100mg #60 x 2 refills is determined to not be medically necessary at this time.

Terocin Lotion 120ml #1 x 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Capsaicin section, Topical Analgesics section Page(s): 28, 111.

Decision rationale: Terocin is a combination medication containing the active ingredients methyl salicylate, capsaicin, lidocaine and menthol. Per Chronic Pain Medical Treatment Guidelines 8 C.C.R. §§9792.20 - 9792.26 MTUS (Effective July 18, 2009), topical capsaicin is: Recommended only as an option in patients who have not responded or are intolerant to other treatments. Formulations: Capsaicin is generally available as a 0.025% formulation (as a treatment for osteoarthritis) and a 0.075% formulation (primarily studied for post-herpetic neuralgia, diabetic neuropathy and post-mastectomy pain). There have been no studies of a 0.0375% formulation of capsaicin and there is no current indication that this increase over a 0.025% formulation would provide any further efficacy. Indications: There are positive randomized studies with capsaicin cream in patients with osteoarthritis, fibromyalgia, and chronic non-specific back pain, but it should be considered experimental in very high doses. Although topical capsaicin has moderate to poor efficacy, it may be particularly useful (alone or in conjunction with other modalities) in patients whose pain has not been controlled successfully with conventional therapy. The number needed to treat in musculoskeletal conditions was 8.1. The number needed to treat for neuropathic conditions was 5.7. (Robbins, 2000) (Keitel, 2001) (Mason-BMJ, 2004) The results from this RCT support the beneficial effects of 0.025% capsaicin cream as a first-line therapy for OA pain. (Altman, 1994) Mechanism of action: Capsaicin, which is derived from chili peppers, causes vasodilation, itching, and burning when applied to the skin. These actions are attributed to binding with nociceptors, which causes a period of enhanced sensitivity followed by a refractory period of reduced sensitivity. Topical capsaicin is superior to placebo in relieving chronic neuropathic and musculoskeletal pain. Capsaicin produces highly selective regional anesthesia by causing degeneration of capsaicin-sensitive nociceptive nerve endings, which can produce significant and long lasting increases in nociceptive thresholds. (Maroon, 2006) Adverse reactions: Local adverse reactions were common (one out of three patients) but seldom serious (burning, stinging, erythema). Coughing has also been reported. See also CRPS, medications; Topical analgesics. Furthermore, these guidelines report that topical analgesics are: Recommended as an option as indicated below. Largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. (Namaka, 2004) These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. (Colombo, 2006) Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, loc