MAXIMUS Federal Services

Case Number:	CM15-0131709		
Date Assigned:	07/17/2015	Date of Injury:	10/30/2014
Decision Date:	09/01/2015	UR Denial Date:	06/24/2015
Priority:	Standard	Application Received:	07/07/2015

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:

The injured worker is a 25 year old male who sustained an industrial injury on October 30, 2014. He has reported injury to the mouth, head, neck, and shoulders and has been diagnosed with post-concussion syndrome, chronic headaches, neck pain, lightheadedness, and status post bone graft and dental extractions. Treatment has included dental surgery and medications. Bulk, tone and power were 5 out 5 for proximal and distal muscles. There was no difficulty with rapid alternating or successive movements with either upper extremity. There was tenderness in the trapezii. There was some tenderness in the temporalis but no clicking in his jaw. The treatment request included vestibular and balance therapy x 6 visits, Elavil, Tylenol, and Motrin.

IMR ISSUES, DECISIONS AND RATIONALES

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

Vestibular and balance therapy x 6 visits: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Head (updated 01/21/15- Online Version Vestibular PT rehabilitation.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Head/Vestibular PT rehabilitation.

Decision rationale: The request is for the vestibular and balance therapy. The MTUS guidelines are silent regarding this topic. As such, ODG is referenced and state the following: Recommended for patients with vestibular complaints (dizziness and balance dysfunction), such as with mTBI/ concussion. Vestibular rehabilitation has been shown to be associated with improvements in independence and dynamic visual acuity. (Cohen, 2006) Vestibular rehabilitation should be considered in the management of individuals post concussion with dizziness and gait and balance dysfunction that do not resolve with rest. (Alsalaheen, 2010) Vestibular complaints are the most frequent sequelae of mTBI, and vestibular physical therapy has been established as the most important treatment modality for this group of patients. (Gottshall, 2011) The use of vestibular rehabilitation for persons with balance and vestibular disorders improves function and decreases dizziness symptoms. (Whitney, 2011) A 6-month physical therapist-prescribed [redacted], based on the [redacted] and [redacted] and [redacted], significantly improved outcomes relative to the control group. (Yang, 2012) Patients with vestibular symptoms after concussion may have slower reaction times, putting them at risk for new injury compared with those who have concussions without these symptoms. A patient who is identified as having a convergence insufficiency should be prescribed in-office and home-based vision therapy designed to improve this visual deficit. In contrast, a patient identified as having predominately dizziness-related vestibular impairment from post-traumatic migraine or cervicogenic factors might be targeted with specific medications for migraine symptoms or physical therapy if it is neck-related. (Kontos, 2013) In this case, the patient has been diagnosed with post-concussion syndrome with associated complaints of dizziness. There are inadequate physical exam findings of gait and balance disturbance. The exam on June 12, 2015 states "walking was normal including arm swing and tandem gait". As such, the request is not medically necessary.

Tylenol 500mg, #150 with 1 refill: Overturned

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 Page(s): 11-12 of 127.

Decision rationale: The request is for the use of acetaminophen for his chronic pain. The MTUS guidelines state the following regarding its use: Recommended for treatment of chronic pain & acute exacerbations of chronic pain. With new information questioning the use of NSAIDs, acetaminophen should be recommended on a case by case basis. The side effect profile of NSAIDs may have been minimized in systematic reviews due to the short duration of trials. On the other hand, it now appears that acetaminophen may produce hypertension, a risk similar to that found for NSAIDs. In this case, the patient has been diagnosed with post-concussive syndrome with chronic headaches. The use of acetaminophen would be indicated

for use. As such, the request is medically necessary.

Motrin 400mg, #150 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-68, 72.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-68 of 127.

Decision rationale: The request is for the use of NSAIDS to aid in pain relief. NSAIDS are usually used to aid in pain and inflammation reduction. The MTUS guidelines states that for osteoarthritis NSAIS are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, for those with gastrointestinal, cardiovascular or renovascular risk factors. NSAIDs appear to be superior to acetaminophen especially for patients with moderate to severe pain. There is no evidence to support one drug in this class over another based on efficacy. In particular, there appears to be no difference between NSAIDs and COX-2 NSAIDs in terms of pain relief. The main concern of selection is based on adverse effects, with COX-2 NSAIDs having fewer GI side effects at the risk of increased cardiovascular side effects. The FDA has concluded that long-term clinical trials are best interpreted to suggest that cardiovascular risk occurs with all NSAIDs and is a class effect (with naproxen being the safest drug). There is no evidence of long-term effectiveness for pain and function. (Chen, 2008) (Laine, 2008) For back pain, NSAIDS are recommended as a second-line treatment after acetaminophen. In general, there is conflicting evidence that NSAIDs are more effective that 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) In this case, there is inadequate documentation of functional improvement to justify continued use, as the guidelines recommend the lowest dose for the shortest period of time. The significant side effect profile of medications in this class put the patient at risk when used chronically. As such, the request is not medically necessary.

Elavil 10mg, #100 with 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13-15.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Antidepressants for chronic pain.

Decision rationale: Medications in the class of Tricyclic antidepressants are recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. (Feuerstein, 1997) (Perrot, 2006) They are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. Analgesia generally occurs within a few days to a week, whereas antidepressant effect usually takes longer to occur. (Saarto-Cochrane, 2005) Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality/duration, and psychological assessment. Side effects can include excessive sedation and should be assessed. It is recommended that these outcome measurements should be initiated at one week of treatment with a recommended trial of at a minimum of 4 weeks. It has been suggested that if pain is in remission for 3-6 months, a gradual tapering of anti-depressants can be undertaken. In this case, the use of this medication is not indicated based on the guidelines due to the lack of assessment of treatment efficacy for ongoing use. As such, the request is not medically necessary.