

Case Number:	CM15-0164208		
Date Assigned:	09/01/2015	Date of Injury:	02/05/2014
Decision Date:	10/15/2015	UR Denial Date:	08/06/2015
Priority:	Standard	Application Received:	08/20/2015

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: Arizona, Michigan
 Certification(s)/Specialty: Preventive Medicine, Occupational 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 48 year old female, who sustained an industrial injury on 2-5-2014. She reported cumulative trauma of the shoulders, arms, neck, and chest. The injured worker was diagnosed as having discogenic cervical condition with facet inflammation and radiculopathy, bilateral shoulder impingement left greater than right, rotator cuff strain and biceps tendinitis, acute acromioclavicular joint inflammation on the left, lateral epicondylitis on the left, and ulnar neuritis bilaterally, myofascial pain syndrome, bilateral shoulder strain, rotator cuff tendinosis, cervical strain and spondylosis. Treatment to date has included medications, physical therapy and QME (January 2015). The request is for physical therapy of the cervical spine and upper extremities, Protonix, and Flexeril. On 1-16-2015, she was seen by QME who recommended 24 physical therapy treatments. On 6-16-2015, she denied gastrointestinal issues. On 7-24-2015, she reported pain to the neck, shoulders, and upper extremities. She is temporarily partially disabled. The treatment plan included: physical therapy, gym membership, trigger point injections, cortisone injections, synvisc injections, TENS unit, acupuncture trial, cervical pillow, naproxen and a muscle relaxant (Flexeril), and Protonix. The records indicate she had received physical therapy in 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy for the Cervical Spine and Upper Extremities Qty: 12: Upheld

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

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Initial Care, and Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

Decision rationale: The ACOEM states that manipulation has been compared to various treatments, but not placebo or non-treatment, for patients with neck pain in nearly twenty randomized clinical trials. More than half favored manipulation, with one reporting better results in combination with exercise, while the remainder indicated treatments were equivocal. Cervical manipulation has not yet been studied in workers' compensation populations. In rare instances (estimated at 1.0-1.5 per million manipulations), manipulation has been associated with cerebrovascular accident. Some studies suggest that this risk is based on the position of the patient, not the act of manipulation itself. Serious side effects are extremely rare and far less frequent than those associated with commonly prescribed alternatives such as non-steroidal anti-inflammatory drugs (NSAIDs), but the issue is currently under study and should be monitored. Using cervical manipulation may be an option for patients with occupationally related neck pain or cervicogenic headache. Consistent with application of any passive manual approach in injury care, it is reasonable to incorporate it within the context of functional restoration rather than for pain control alone. There is insufficient evidence to support manipulation of patients with cervical radiculopathy. Per the CA MTUS physical medicine is recommended with certain indications. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. Physical Medicine Guidelines - Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Myalgia and myositis, unspecified (ICD9 729.1): 9-10

visits over 8 weeks. Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 weeks. Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks. In this case, it is indicated she completed unknown amount of physical therapy in 2014. The documentation of the efficacy of the received physical therapy is not available for this review. It is unclear if functional benefit was attained from the previous physical therapy sessions. Therefore, the request for Physical Therapy for the Cervical Spine and Upper Extremities Qty: 12 is not medically necessary.

Protonix 20mg #60: 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): NSAIDs, GI symptoms & cardiovascular risk. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, proton pump inhibitors.

Decision rationale: The CA MTUS does not directly address Protonix. The ODG and CA MTUS guidelines recommend proton pump inhibitors (PPIs) for patients at risk for gastrointestinal events. Prilosec (omeprazole), Prevacid (lansoprazole) and Nexium (esomeprazole magnesium) are PPIs. Healing doses of PPIs are more effective than all other therapies, although there is an increase in overall adverse effects compared to placebo. Nexium and Prilosec are very similar molecules. In general, the use of a PPI should be limited to the recognized indications and used at the lowest dose for the shortest possible amount of time. PPIs are highly effective for their approved indications, including preventing gastric ulcers induced by NSAIDs. Studies suggest, however, that nearly half of all PPI prescriptions are used for unapproved indications or no indications at all. Many prescribers believe that this class of drugs is innocuous, but much information is available to demonstrate otherwise. Products in this drug class have demonstrated equivalent clinical efficacy and safety at comparable doses, including esomeprazole (Nexium), lansoprazole (Prevacid), omeprazole (Prilosec), pantoprazole (Protonix), dexlansoprazole (Dexilant), and rabeprazole (Aciphex). Risks: Decisions to use PPIs long-term must be weighed against the risks. The potential adverse effects of long-term PPI use include B12 deficiency; iron deficiency; hypomagnesemia; increased susceptibility to pneumonia, enteric infections, and fractures; hypergastrinemia and cancer; and more recently adverse cardiovascular effects. PPIs have a negative effect on vascular function, increasing the risk for myocardial infarction (MI). Patients with gastroesophageal reflux disease on PPIs had a 1.16 greater risk of MI, and a 2.00 risk for cardiovascular mortality. PPI usage may be serving as a marker for a sicker population, but this is unlikely, given the lack of increased risk seen in patients taking H2 blockers. The gastrointestinal event risk factors include: age over 65 years, history of peptic ulcer, GI (gastrointestinal) bleeding or perforation, concurrent use of ASA (aspirin), corticosteroids, and/or an anticoagulant, or high dose or multiple oral NSAID (non-steroidal anti-inflammatory drug) use. In this case, the injured worker is 48 years old. She has denied gastrointestinal issues. There is no history of peptic ulcer, GI (gastrointestinal) bleeding or perforation, concurrent use of ASA (aspirin), corticosteroids, and/or an anticoagulant, or high dose or multiple oral NSAID (non-steroidal anti-inflammatory drug) use. Therefore, the request for Protonix 20mg #60 is not medically necessary.

Flexeril 7.5mg #60: 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): Cyclobenzaprine (Flexeril), Muscle relaxants (for pain).

Decision rationale: Per the CA MTUS, Cyclobenzaprine (Flexeril) is an antispasmodic muscle relaxant. Non-sedating muscle relaxants are recommended with caution as a second line option for short term treatment of acute exacerbations in patients with chronic low back pain. Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. Antispasmodics are used to decrease muscle spasm in conditions such as low back pain although it appears that these medications are often used for the treatment of musculoskeletal conditions whether spasm is present or not. The mechanism of action for most of these agents is not known. Cyclobenzaprine is recommended for a short course therapy. There is limited, mixed evidence that does not allow for recommendation for chronic use. The CA MTUS states, Cyclobenzaprine (Flexeril) is recommended as an option, using a short course of therapy. Cyclobenzaprine (Flexeril) is more effective than placebo in the management of back pain; the effect is modest and comes at the price of greater adverse effects. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. Treatment should be brief. There is also a post-op use. The addition of cyclobenzaprine to other agents is not recommended. Cyclobenzaprine-treated patients with fibromyalgia were 3 times as likely to report overall improvement and to report moderate reductions in individual symptoms, particularly sleep. Cyclobenzaprine is closely related to the tricyclic antidepressants, e.g., amitriptyline. Cyclobenzaprine is associated with a number needed to treat of 3 at 2 weeks for symptom improvement in LBP and is associated with drowsiness and dizziness. Cyclobenzaprine is a skeletal muscle relaxant and a central nervous system (CNS) depressant. According to the CA MTUS all therapies must be focused on the goal of functional restoration rather than just the elimination of pain and assessment of treatment efficacy is accomplished by reporting functional improvement, with functional improvement being documented in reduction of pain, increased pain control, and improved quality of life. Functional improvement means either a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam, performed and documented as part of the evaluation and management visit; and a reduction in the dependency on continued medical treatment. In this case, there is indication of long term use of muscle relaxants without documented benefit. There is a lack of functional improvement with the treatment already provided. The treating physician did not provide sufficient evidence of improvement in the work status, activities of daily living, and dependency on continued medical care. Therefore, the request for Flexeril 7.5mg #60 is not medically necessary.