

Case Number:	CM15-0189567		
Date Assigned:	10/01/2015	Date of Injury:	01/19/2015
Decision Date:	12/03/2015	UR Denial Date:	09/11/2015
Priority:	Standard	Application Received:	09/25/2015

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 42 year old female, who sustained an industrial injury on 01-19-2015. She has reported subsequent neck and back pain and was diagnosed with C4-C5 and C5-C6 degenerative disk disease, chronic neck pain, diffuse thoracic spondylosis and Arnold-Chiari syndrome. MRI of the cervical spine on 2-27-2015 was noted to show no significant change in inferior displacement of the cerebellar tonsils approximately 5 mm inferior to foramen magnum, uncovertebral spurring and facet hypertrophy with moderate left C2-C3, mild bilateral C3-C4 and moderate right C4-C5 foramina stenoses. Treatment to date has included pain medication, 13 sessions of acupuncture and 50 + sessions of physical therapy. Acupuncture was noted to have provided great improvement and helped decrease headaches. The most recent progress note indicates that physical therapy provided increased range of motion and decreased pain at the mid and low back, however a progress note in June 2015 shows that physical therapy was making things worse. Documentation shows that Flexeril was prescribed at least since 05-12-2015 and Treximet was prescribed for Migraines since at least 06-05-2015. Medications were noted to help decrease pain by 50% for 5 hours. Work status was documented as modified. In a progress note dated 07-20-2015, the injured worker reported constant pinching pain in the neck that was rated as 8 out of 10 and felt "like there is a knife stabbing me on top of my head." Pain was noted to be primarily right sided with a bruised sensation at the base of the skull and continued migraines 3 times per week. The injured worker reported fainting at a recent softball game. Objective examination findings revealed tenderness to palpation in the right cervical paraspinals with spasms, tenderness to palpation in the bilateral paraspinals of the thoracic and lumbar spine,

decreased range of motion in the cervical, thoracic and lumbar spine and positive Spurling's on the right. A request for authorization of Cyclobenzaprine 7.5 mg qty 30, Treximet #10 85-500 mg qty 10, acupuncture, cervical spine, 2 times weekly for 4 weeks, 8 sessions and neurology consultation was submitted. As per the 09-11-2015 utilization review, the aforementioned requests were non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cyclobenzaprine 7.5mg Qty 30: 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): Muscle relaxants (for pain).

Decision rationale: The request is for the use of a muscle relaxant to aid in pain relief. The MTUS guidelines state that the use of a medication in this class is indicated as a second-line option for short-term treatment of acute exacerbations of low back pain. Muscle relaxants may be effective in reducing pain and muscle tension, which can increase mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain improvement. Efficacy appears to diminish over time, and prolonged use may lead to dependence. (Homik, 2004) Due to inadequate documentation of a recent acute exacerbation and poor effectiveness for chronic long-term use, the request is not medically necessary.

Treximet #10 85/500 mg Qty 10: Upheld

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

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

Decision rationale: The request is for the use a product which has the active ingredient Sumatriptan. The official disability guidelines state the following regarding this topic: Recommended for migraine sufferers. At marketed doses, all oral triptans (e.g., Sumatriptan, brand name Imitrex) are effective and well tolerated. Differences among them are in general relatively small, but clinically relevant for individual patients. A poor response to one triptan does not predict a poor response to other agents in that class. (Adelman, 2003) (Ashcroft, 2004) (Belsey, 2004) (Brandes 2005) (Diener, 2005) (Ferrari, 2003) (Gerth, 2001) (Mannix, 2005) (Martin 2005) (McCroory, 2003) (Moschiano, 2005) (Moskowitz, 1992) (Sheftell, 2005) Rizatriptan (Maxalt) has demonstrated, in a head-to-head study, higher response rates and a more rapid onset of action than Sumatriptan, together with a favorable tolerability profile. Meta-analyses of double-blind placebo-controlled studies have confirmed the superior efficacy of Rizatriptan. (Gbel, 2010) While the Maxalt brand of Rizatriptan therapy is more expensive than

other triptans, the economic value of Rizatriptan depends on the payer's perspective, as the greatest savings can be expected to be achieved in terms of reduced migraine-related loss of work productivity compared with less effective treatments. (Mullins, 2007) (McCormack, 2005) According to the FDA Orange Book, equivalent generics have been approved for Maxalt, so generic Rizatriptan would be recommended. (FDA, 2013) See also Migraine pharmaceutical treatment. As stated above, Sumatriptan is indicated for migraine headaches. In this case, the product requested is combined with an NSAID. There is inadequate evidence of superior efficacy of this medication as opposed to Sumatriptan alone. There is also no documentation of why the patient could not take Sumatriptan and an NSAID separately. As such, the request is not medically necessary.

Acupuncture, cervical spine, 2 times weekly for 4 weeks, 8 sessions: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & upper back (acute & chronic)/Acupuncture.

Decision rationale: The request is for acupuncture of the neck. The official disability guidelines state the following regarding this topic: Under study for upper back, but not recommended for neck pain. Despite substantial increases in its popularity and use, the efficacy of acupuncture for chronic mechanical neck pain still remains unproven. Acupuncture reduces neck pain and produces a statistically, but not clinically, significant effect compared with placebo. The beneficial effects of acupuncture for pain may be due to both nonspecific and specific effects. (White, 2004) Acupuncture is superior to conventional massage, dry needling of local myofascial trigger points, and sham laser acupuncture, for improving active range of motion and pain in patients with chronic neck pain, especially in patients with myofascial pain syndrome. (Blossfeldt, 2004) (Konig, 2003) (Irnich, 2002) (Irnich, 2001) There is limited or conflicting evidence from clinical trials that acupuncture is superior to sham or active controls for relief of neck pain. There is moderate evidence that acupuncture is more effective than wait-list control for neck disorders with radicular symptoms. (Trinh, 2007) A recent study concluded that adequate acupuncture treatment may reduce chronic pain in the neck and shoulders and related headache, and the effect lasted for 3 years. (He, 2004) There is little information available from trials to support the use of many physical medicine modalities for mechanical neck pain, often employed based on anecdotal or case reports alone. In general, it would not be advisable to use these modalities beyond 2-3 weeks if signs of objective progress towards functional restoration are not demonstrated. (Kjellman, 1999) (Gross-Cochrane, 2002) (Aker, 1996) (Bigos, 1999) (Gross-Cochrane, 2004) (Birch, 2004) Another recent trial found that acupuncture is more effective than TENS placebo treatment. (Vas, 2006) This passive intervention should be an adjunct to active rehab efforts. For an overview of acupuncture and other conditions in which this modality is recommended see the Pain Chapter. ODG Acupuncture Guidelines: Initial trial of 3-4 visits over 2 weeks. With evidence of objective functional improvement, total of up to 8-12 visits over 4-6 weeks (Note: The evidence is inconclusive for repeating this procedure beyond an initial short course of therapy). In this case, this treatment modality is not indicated. As clearly

stated above, due to poor scientific evidence of efficacy, acupuncture of the neck is not supported. As such, the request is not medically necessary.

Neurology consultation: Upheld

Claims Administrator guideline: Decision based on MTUS General Approaches 2004, Section(s): Cornerstones of Disability Prevention and Management. Decision based on Non-MTUS Citation ACOEM Occupational Medicine Practice Guidelines, Chapter 7: Independent Medical Examinations and Consultations, page 127, 112.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (chronic)/Office visits.

Decision rationale: The request is for a specialty consultation. The MTUS guidelines are silent regarding this issue. The ODG state the following: Recommended as determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible. The ODG Codes for Automated Approval (CAA), designed to automate claims management decision-making, indicates the number of E&M office visits (codes 99201-99285) reflecting the typical number of E&M encounters for a diagnosis, but this is not intended to limit or cap the number of E&M encounters that are medically necessary for a particular patient. Office visits that exceed the number of office visits listed in the CAA may serve as a "flag" to payors for possible evaluation, however, payors should not automatically deny payment for these if preauthorization has not been obtained. Note: The high quality medical studies required for treatment guidelines such as ODG provides guidance about specific treatments and diagnostic procedures, but not about the recommended number of E&M office visits. Studies have and are being conducted as to the value of "virtual visits" compared with inpatient visits; however the value of patient/doctor interventions has not been questioned. (Dixon, 2008) (Wallace, 2004) Further, ODG does provide guidance for therapeutic office visits not included among the E&M codes, for example Chiropractic manipulation and Physical/Occupational therapy. See also [REDACTED]. In this case, the request is not certified. This is secondary to poor documentation as to the reasoning for the visit and consultation. There is inadequate discussion of the specific issue requiring further evaluation and assessment. The MRI performed at [REDACTED] on 2/27/2015 showed no significant change in inferior displacement of the cerebellar tonsils and no evidence of high grade canal stenosis at any level. If the patient was thought to be a surgical candidate, then a neurosurgery consult would be warranted.

