

<b>Case Number:</b>	CM15-0206561		
<b>Date Assigned:</b>	10/27/2015	<b>Date of Injury:</b>	06/06/2015
<b>Decision Date:</b>	12/31/2015	<b>UR Denial Date:</b>	09/29/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/20/2015

### 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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 28 year old female who sustained an industrial injury on 06-06-2015. A review of the medical records indicated that the injured worker is undergoing treatment for head, neck and facial injuries, concussion, migraines, musculoskeletal headaches, cognitive impairment and cervical spasm. The injured worker has a history of previous concussions and mood disorder. According to the treating physician's progress report on 09-02-2015, the injured worker continues to experience headaches 3-4 times a week. Mental status was evaluated and noted as less depressed and sensitive with orientation times 3. Cranial nerves II through XII intact. The paracervical area noted spasm. There was pain noted over the temporal mandibular joints. Motor strength, deep tendon reflexes and sensory of all extremities was intact with normal gait. Cerebellar function was within normal limits. Prior treatments have included chiropractic therapy, neurology consultation and medications. Current medications were listed as Fioricet, Motrin, Flexeril (at least since 08-19-2015), Nuedexta (at least since 08-19-2015), Aricept and Pamelor. There were no diagnostic reports included or reviewed in the medical records. Treatment plan consists of increase Nuedexta to twice a day and the current request for Flexeril 10mg #30, Nuedexta 20-10mg #30, cervical spine X-ray, and chiropractic therapy twice a week for 3 weeks for the cervical spine, physical therapy twice a week for 3 weeks for the head and neck, follow-up visit with psychologist and facial X-rays. Notes indicate that the patient has undergone chiropractic care. Nuedexta has reportedly helped. Notes indicate that cervical x-rays have not been done. On 09-29-2015 the Utilization Review determined the requests for Flexeril 10mg #30, Nuedexta 20-10mg #30, cervical spine X-ray, chiropractic therapy twice a week for 3

weeks for the cervical spine, physical therapy twice a week for 3 weeks for the head and neck, follow-up visit with psychologist and facial X-rays were not medically necessary.

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

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

**Flexeril 10mg, #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

**Decision rationale:** Regarding the request for cyclobenzaprine (Flexeril), Chronic Pain Medical Treatment Guidelines support the use of non-sedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Guidelines go on to state that cyclobenzaprine specifically is recommended for a short course of therapy. Within the documentation available for review, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the cyclobenzaprine. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. Finally, there is no documentation of failure of first-line treatment options, as recommended by guidelines. In the absence of such documentation, the currently requested cyclobenzaprine (Flexeril) is not medically necessary.

**Nuedexta 20/10mg, #30:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) 2015, Mental Illness & Stress, Nuedexta.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.drugs.com/nuedexta.html>.

**Decision rationale:** Regarding the request for Nuedexta 20/10mg, #30, California MTUS and ODG do not address the issue. Drugs.com states that Nuedexta is used to treat involuntary outbursts of crying or laughing in people with certain neurological disorders. Within the information made available for review, there is documentation of involuntary outbursts of crying as a result of a Traumatic Brain Injury, which have improved with Nuedexta. As such, the currently requested Nuedexta 20/10mg, #30 is medically necessary.

**X-ray of the cervical spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies.

**MAXIMUS guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Diagnostic Criteria, Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back Chapter, Radiography.

**Decision rationale:** Regarding request for cervical spine x-ray, Occupational Medicine Practice Guidelines state that x-rays should not be recommended in patients with neck pain in the absence of red flags for serious spinal pathology even if the pain has persisted for at least 6 weeks. However, it may be appropriate when the physician believes it would aid in patient management. Guidelines go on to state that subsequent imaging should be based on new symptoms or a change in current symptoms. Within the documentation available for review, it is unclear why cervical imaging is needed at the current time. It does not appear that the patient has failed conservative treatment. Additionally, the requesting physician has not stated how his medical decision-making will be changed based upon the outcome of the currently requested cervical x-ray. In the absence of clarity regarding those issues, the currently requested cervical x-ray is not medically necessary.

**Chiropractic 2x a week for 3 weeks for the cervical 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) Neck and Upper Back, Manipulation ODG Chiropractic Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

**Decision rationale:** Regarding the request for additional chiropractic care, Chronic Pain Medical Treatment Guidelines support the use of chiropractic care for the treatment of chronic pain caused by musculoskeletal conditions. Guidelines go on to recommend a trial of up to 6 visits over 2 weeks for the treatment of low back pain. With evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks may be supported. Within the documentation available for review, there is documentation of completion of prior chiropractic sessions, but there is no documentation of specific objective functional improvement with the previous sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. In the absence of clarity regarding the above issues, the currently requested chiropractic care is not medically necessary.

**Physical therapy 2x per week for 3 weeks for the head and neck:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back Chapter, Physical Therapy.

**Decision rationale:** Regarding the request for physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is no indication that the patient has undergone physical therapy previously. Additionally, the patient has substantial symptoms limiting function. As such, the utilization of physical therapy seems reasonable. A trial of 6-visits is consistent with guideline recommendations. As such, the current request for physical therapy is medically necessary.

**Follow-up visit with psychologist:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM) Occupational Practice Guidelines, Second Edition (2004), Chapter 7 page 127.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Psychological treatment. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain, Behavioral Interventions.

**Decision rationale:** Regarding the request for psychological follow-up, Chronic Pain Medical Treatment Guidelines state that psychological evaluations are recommended. Psychological evaluations are generally accepted, well-established diagnostic procedures not only with selected using pain problems, but also with more widespread use in chronic pain populations. Diagnostic evaluations should distinguish between conditions that are pre-existing, aggravated by the current injury, or work related. Psychosocial evaluations should determine if further psychosocial interventions are indicated. ODG states the behavioral interventions are recommended. Guidelines go on to state that an initial trial of 3 to 4 psychotherapy visits over 2 weeks may be indicated. Within the documentation available for review, it appears the patient has substantial cognitive deficits from the traumatic brain injury including emotional lability and depression. As such, further treatment with a psychologist seems reasonable to address these issues. Therefore, the currently requested psychological follow-up is medically necessary.

**X-ray, facial:** 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) 2015, Head, X-rays.

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

**Decision rationale:** Regarding the request for hip x-ray, California MTUS does not contain criteria for hip radiographs. ODG states that had x-rays are recommended if CT scans are not available. CT scans are preferred for diagnosis of fractures as well as contusion or hemorrhage. Within the documentation available for review, it is unclear why a facial x-rays being requested at the current time. Additionally, it is unclear why CT scan would be insufficient to address any current concerns. Finally, it is unclear how the requesting physician's decision-making will be changed based upon the outcome of the requested study. In the absence of clarity regarding those issues, the currently requested face x-ray is not medically necessary.