MAXIMUS Federal Services

Case Number:	CM15-0079281		
Date Assigned:	04/30/2015	Date of Injury:	05/13/2013
Decision Date:	09/01/2015	UR Denial Date:	04/13/2015
Priority:	Standard	Application Received:	04/24/2015

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 38-year-old male, with a reported date of injury of 05/13/2013. The diagnoses include back sprain and migraine headaches. Treatments to date have included oral medications, physical therapy, and topical pain medication. The progress report dated 03/25/2015 indicates that the injured worker had dizziness and vestibular dysfunction. He complained of dizziness most frequently when concentrating in a sitting position. There was nausea with the experience and a headache followed the episode. The objective findings include normal tympanic membranes, and a normal mini-mental examination. The treating physician requested an MRI of the brain, Mexalt 10mg #20, Tylenol 650mg #90, Ibuprofen 600mg #90, a hearing test, and gabapentin 300mg #90 with three refills.

IMR ISSUES, DECISIONS AND RATIONALES

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

Magnetic resonance imaging (MRI) of the brain: 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) Head Chapter, MRI.

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

Decision rationale: The request is for an MRI of the head. The MTUS and ACOEM guidelines are silent regarding this issue. The ODG guidelines state the following: Recommended as indicated below. Magnetic Resonance Imaging (MRI) is a well-established brain imaging study in which the individual is positioned in a magnetic field and a radio-frequency pulse is applied. Hydrogen proton energy emission is translated into visualized structures. Normal tissues give off one signal, while abnormal structures give off a different signal. Due to its high contrast resolution, MRI scans are superior to CT scans for the detection of some intracranial pathology, except for bone injuries such as fractures. MRI may reveal an increased amount of pathology as compared with CT. Specific MRI sequences and techniques are very sensitive for detecting traumatic cerebral injury; they may include, but are not limited to, diffusion-tensor, gradient echo, and Fluid Attenuated Inversion Recovery (FLAIR). Some of these techniques are not available on an emergency basis. MRI scans are useful to assess transient or permanent changes, to determine the etiology of subsequent clinical problems, and to plan treatment. MRI is more sensitive than CT for detecting traumatic cerebral injury. (Colorado, 2005) (Intracorp, 2005) (Takanashi, 2001) Neuroimaging is not recommended in patients who sustained a concussion/mild TBI beyond the emergency phase (72 hours post-injury) except if the condition deteriorates or red flags are noted. (Cifu, 2009) See also Diffusion tensor imaging (DTI). Indications for magnetic resonance imaging: To determine neurological deficits not explained by CT, To evaluate prolonged interval of disturbed consciousness, To define evidence of acute changes super-imposed on previous trauma or disease. In this case, the patient has documented cognitive deficits which are persistent since his injury. There is documentation of a change in his neurologic status with weakness of the right upper extremity seen on April of 2015. As stated above, an MRI is more sensitive the CT for detecting traumatic cerebral injury. As such, criteria has been met for an MRI and the request is medically necessary.

Maxalt 10mg, #20: Overturned

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) Rizatriptan (Maxalt®).

Decision rationale: The request is for the use of the medication Maxalt. The MTUS and ACOEM guidelines are silent regarding its use but the ODG guidelines state the following: Recommended for migraine sufferers. See Triptans. Rizatriptan (Maxalt) is a triptan drug developed by [redacted]. for the treatment of migraine headaches. 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, savings can be expected in 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) In this case there is documentation of a post-traumatic migraine headache which is persistent. He also has significant pain relief with its use and continued treatment as such would be advised. As such, the request is medically necessary.

Tylenol 650mg, #90: 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 documented chronic pain in his thoracic spine after a significant traumatic injury which occurred. The guidelines do advise the use of acetaminophen for chronic pain including osteoarthritis. As such, the request is medically necessary.

Ibuprofen 600mg, #90: 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): 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 naproxyn 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 adequate documentation of functional improvement to justify continued use. As such, the request is medically necessary.

Hearing test: 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) Head Chapter, Audiometry.

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

Decision rationale: The MTUS guidelines are silent regarding audiometry. The ODG guidelines are referenced below: Recommended following brain injury or when occupational hearing loss is suspected. Audiometry is a generally accepted and well-established procedure that measures hearing. An audiologist or skilled trained technician administers the test using an audiometer. The machine presents individual frequencies to the patient (typically ranging from 125-8000 Hz) at different levels of loudness (in dBHL). The patient is asked to respond to the sound that he may barely perceive (threshold). Normal thresholds are from 0-25 dB HL. The results are displayed in normal graphic form or on audiogram. The audiologist or physician may determine the presence and type (conductive, sensorineural, or mixed) of hearing loss based on the audiogram. Baseline audiometry following brain injury is indicated when the individual with TBI presents with hearing loss, dizziness, tinnitus, or facial nerve dysfunction. Audiograms may be obtained in serial fashion to monitor inner ear function in response to time and treatment. (Mueller, 2005) Clinical indications from the American Speech Hearing Association (ASHA), the professional, scientific, and credentialing association for audiologists, include: (1) Screen as needed, requested, or when patients have conditions that place them at risk for hearing impairment, such as recreational noise exposure, family history and concern of family member; & (2) Screen at least every decade through age 50 and at 3-year intervals thereafter. The Panel also recommended a three-component screening protocol for adults. This should include screening for hearing disorder, hearing impairment and hearing disability. Prior to the hearing screening, a case history and visual inspection of the ear is advised to identify persons with significant otologic history or obvious anatomic abnormalities of the ear. The pure tone hearing screening should to be conducted at 25 dB HL for 1000, 2000 and 4000 Hz in each ear. Hearing impairment is defined as unilateral or bilateral sensorineural and/or conductive hearing levels greater than 20 dB HL. (ASHA, 2011)As stated above autiometry is indicated for patients with head trauma with hearing deficits or those that have occupations which place them at risk for hearing loss. There is inadequate documentation of hearing loss seen in the records which would

prompt a full exam by an audiologist. There is also no reference as to why the request was made. As such, the request is not medically necessary.

Gabapentin 300mg, #90 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs); Gabapentin (Neurontin) Page(s): 16-18, 49.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-17 of 127.

Decision rationale: The request is for the use of a medication in the category of an anti-epileptic drug (AED). These medications are recommended for certain types of neuropathic pain. Most of the randomized clinical control trials involved include post-herpetic neuralgia and painful polyneuropathy such as in diabetes. There are few trials which have studied central pain or radiculopathy. The MTUS guidelines state that a good response to treatment is 50% reduction in pain. At least a 30% reduction in pain is required for ongoing use, and if this is not seen, this should trigger a change in therapy. Their also should be documentation of functional improvement and side effects incurred with use. Disease states which prompt use of these medications include post-herpetic neuralgia, spinal cord injury, chronic regional pain syndrome, lumbar spinal stenosis, post-operative pain, and central pain. There is inadequate evidence to support use in non-specific axial low back pain or myofascial pain. In this case, there is inadequate documentation of a condition which would support the use of an anti-epileptic drug. The records also do not reveal functional improvement or screening measures as required. As such, the request is not medically necessary.