

<b>Case Number:</b>	CM13-0023402		
<b>Date Assigned:</b>	12/20/2013	<b>Date of Injury:</b>	08/28/1997
<b>Decision Date:</b>	04/21/2014	<b>UR Denial Date:</b>	09/06/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/12/2013

### 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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation and is licensed to practice in Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 69-year-old female who reported an injury on 08/28/1997, due to cumulative trauma while performing normal job duties. The patient's most recent clinical evaluation documented that the patient had brachial plexopathy due to significant postoperative complications on the left side, significant scarring in and around the sternocleidomastoid muscle bilaterally above the clavicle. It was noted that the patient had an average pain of 6/10 without medications, reduced to a 3/10 with medications. The patient's medication schedule included Kadian 10 mg, hydrocodone/acetaminophen 10/325 mg, Celexa 20 mg, Bisacodyl EC 5 mg, Senna 8.6-50 mg, Senokot 5 mg, and Neuropath-B. The patient's physical evaluation documented that the patient had tenderness to palpation along the C5-6 musculature with decreased range of motion secondary to pain. Evaluation of the lumbar spine documented that the patient had tenderness to palpation along the L5-S1 with restricted range of motion secondary to pain and positive bilateral sciatic notch tenderness, and a positive straight leg raising test. It was noted that the patient had decreased lower and upper extremity strength and sense of touch. It was noted that the patient was monitored for aberrant behavior with urine drug screens and CURES reports. The patient's treatment history included trigger point injections to the sternocleidomastoid with good benefit. The patient's treatment plan included continuation of medications and physical therapy. A request was made for a sternocleidomastoid injection with ultrasound guidance.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**STERNOCLEIDOMASTOID INJECTION WITH ULTRASOUND GUIDANCE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 3, 48,146, 116-127, 129.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TRIGGER POINT INJECTION Page(s): 121.

**Decision rationale:** The requested sternocleidomastoid injection with ultrasound guidance is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends trigger point injections for patients who have palpable trigger points upon examination. The clinical documentation submitted for review does not provide any evidence that the patient has palpable trigger points upon examination. Additionally, it is noted within the submitted documentation that the patient has previously undergone this type of injection. The California Medical Treatment Utilization Schedule recommends repeat trigger point injections when the patient has at least 50% pain relief for 4 to 6 weeks. The clinical documentation submitted for review does not provide a quantitative assessment of pain relief, documentation of functional benefit, or duration of pain relief. Therefore, an additional sternocleidomastoid injection with ultrasound guidance is not medically necessary or appropriate.

**HYDROCODONE-ACETAMINOPHEN 10/325MG TAB 1 PO QDAY PM FOR SEVERE PAIN, BRAND MEDICALLY NECESSARY #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 82-88, 91.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, ONGOING MANAGEMENT Page(s): 78.

**Decision rationale:** The requested hydrocodone-acetaminophen 10/325 mg tablets 1 every day in the evening for severe pain, brand medically necessary, #30 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends the ongoing use of opioids in the management of chronic pain be supported by a quantitative assessment of pain relief, documentation of functional benefit, evidence that the patient is monitored for aberrant behavior, and managed side effects. The clinical documentation submitted for review does indicate that the patient is monitored for aberrant behavior with urine drug screens and CURES reports. However, the clinical documentation submitted for review does not specifically identify functional improvement. Therefore, continued use would not be supported. As such, the requested hydrocodone-acetaminophen 10/325 mg tablets 1 by mouth every day at night for severe pain, brand medically necessary #30 is not medically necessary or appropriate.