

<b>Case Number:</b>	CM13-0025921		
<b>Date Assigned:</b>	11/22/2013	<b>Date of Injury:</b>	07/09/2009
<b>Decision Date:</b>	01/31/2014	<b>UR Denial Date:</b>	09/06/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/19/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Interventional Spine, and is licensed to practice in California. 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 physician 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 39 year-old female with a date of injury on 07/09/09. The UR determination being challenged is dated 09/06/13 and recommends denial of trigger point injection to the bilateral trapezius and levator scapulae, Percocet, Ambien, Tizanidine, and Medrol pak. Patient has a history of cervical spondylosis, cervical radiculopathy, right shoulder impingement, fibromyalgia, and joint pain. Based on the progress report dated 08/20/2013 by [REDACTED], the patient continues to complain of chronic severe back, shoulder and neck pain. Patient's pain is described as aching, throbbing, shooting, stabbing, burning and sharp. Patient reports average pain without meds is a 9/10 and with meds a 5/10 with increase in mobility and ADL. QME report dated 08/13/2013, shows on examination low grade pain with all maneuvers on right shoulder. It was noted that the right shoulder had a decreased range of motion and left shoulder was within normal range. Joint stability, muscle strength and motor power all noted within normal range. Patient is status post right shoulder arthroscopy, de-impingement surgery and Mumford procedure (2009).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Trigger Point Injections to the trapezius and levator scapulae bilaterally:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Trigger point injections. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines) Pain Chapter, Trigger Point Injections

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Trigger point injections Page(s): 122. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Criteria for Trigger Point Injections

**Decision rationale:** On progress report dated 08/06/2013, treater notes patient has very tender trapezius and levator scapulae bilaterally with taut bands and almost "rock hard tissue." MTUS guidelines have specific criteria for the use of Trigger point injections and recommends injections only for myofascial pain syndrome and not recommended for radicular pain. A trigger point is a discrete focal tenderness located in a palpable taut band of skeletal muscle, which produces a local twitch in response to stimulus to the band. Guidelines indicate trigger point injections when the following criteria are met: (1) Documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain; (2) Symptoms have persisted for more than three months; (3) Medical management therapies such as ongoing stretching exercises, physical therapy, NSAIDs and muscle relaxants have failed to control pain; (4) Radiculopathy is not present (by exam, imaging, or neuro-testing); (5) Not more than 3-4 injections per session; (6) No repeat injections unless a greater than 50% pain relief is obtained for six weeks after an injection and there is documented evidence of functional improvement; (7) Frequency should not be at an interval less than two months; (8) Trigger point injections with any substance (e.g., saline or glucose) other than local anesthetic with or without steroid are not recommended. Patient meets the criteria and an initial injection is warranted. Recommendation is for approval.

**Percocet 10/325 1 tab by mouth (PO) every 4-6 hours as needed for severe pain:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 81.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of Opioids Page(s): 88, 89.

**Decision rationale:** Patient has chronic lower back, neck and shoulder pain. Medical records indicate patient is a long time user of opioids. Earliest medical records provided show patient has been prescribed Percocet since 04/19/2012. The treater does not go into any details regarding the specifics of ADL's or other functional issues such as quality of life, return to work, etc. MTUS guidelines have specific recommendations for long-term users of Opioids (6 months or more). Pain should be assessed at each visit, and functioning should be measured at least once every 6 months using a numerical scale or validated instrument. In this case, the treater does not provide numerical scales to quantify function or before/after medication functional levels. MTUS also requires pain and functional improvements to be compared to baseline to measure efficacy of opioids. Under outcome measurements, MTUS requires documentation of current pain; average pain; least pain; duration of relief with medication; time it takes for medication to take effect, etc. Recommendation is for denial.

**Ambien 10mg one tab PO QHS: 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), Pain Chapter, Zolpidem

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

**Decision rationale:** Treater is requesting a refill for Ambien 10mg. Zolpidem [Ambien(generic available), Ambien CR] is indicated for the short-term treatment of insomnia with difficulty of sleep onset (7-10 days). Medical records show patient has been prescribed Ambien since 11/29/2012. Recommendation is for denial.

**Tizanidine HCL 50mg 1 tab PO q12: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity/Antispasmodic Drugs, Tizanidine Page(s): 66.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67.

**Decision rationale:** Patient has a history of cervical spondylosis, cervical radiculopathy, right shoulder impingement, fibromyalgia, and joint pain. Treater recommends Tizanidine as a treatment plan for patient's symptoms. MTUS chronic pain pg 66 states Tizanidine (Zanaflex, generic available) is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain (Malanga, 2008). Eight studies have demonstrated efficacy for low back pain (Chou, 2007). One study (conducted only in females) demonstrated a significant decrease in pain associated with chronic myofascial pain syndrome and the authors recommended its use as a first line option to treat myofascial pain (Malanga, 2002). Tizanidine may also provide benefit as an adjunct treatment for fibromyalgia (ICSI, 2007). Given patient's diagnoses and symptoms, recommendation is for approval.

**Medrol pak 4mg tabs: 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), oral steroids

**Decision rationale:** Patient has a history of cervical spondylosis, cervical radiculopathy, right shoulder impingement, fibromyalgia, and joint pain. MTUS guidelines do not discuss the use of Medrol Pak 4mg. However, ODG guidelines recommend oral corticosteroids for limited circumstances as noted below for acute radicular pain. Not recommended for acute non-radicular

pain (i.e. axial pain) or chronic pain. Multiple severe adverse effects have been associated with systemic steroid use. This is more likely to occur after long-term use. Medical records show patient has been prescribed Medrol Pak 4mg since 11/29/2012. This medication is not indicated for chronic pain or long term use. Recommendation is for denial.