

Case Number:	CM13-0037615		
Date Assigned:	12/18/2013	Date of Injury:	05/14/2001
Decision Date:	04/21/2014	UR Denial Date:	10/14/2013
Priority:	Standard	Application Received:	10/23/2013

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 and Rehabilitation, has a subspecialty in Pain Management, 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 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:

This patient is a 62-year-old female with date of injury 05/14/2001. Per treating physician report dated 08/21/2013, patient presents with moderately severe low back pain, located in the lower back, neck, and head, and pain has radiated to the right calf and right thigh. Listed assessment: 1. Chronic pain syndrome. 2. Low back pain. 3. Sacroiliac sprain. 4. Radiculopathy, thoracic and lumbosacral. 5. Facet arthropathy to lumbar spine. 6. Spondylosis lumbar without myelopathy. Report by [REDACTED] July 11, 2013. This patient is retired, and there is a long list of different medications including hydroxyzine 50 mg up to q.i.d. Subjective presenting symptoms are battling with depression, waiting for decision regarding radiofrequency ablation, and patient is towards the end of psych for Botox, continuous headaches, "review suggests RFA last about 2.5 months for the lumbar spine." [REDACTED] also documents "trigger point injections to neck for headaches greater than 50% for two months." Numerous reports were reviewed including [REDACTED] reports from 2013. These reports include dates from 01/04/2013 to September 18, 2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

PERIODIC TRIGGER POINT INJECTIONS UP TO 4 PER YEAR: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MTUS Chronic Pain Medical Treatment Guidelines, Trigger Point Inje.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MTUS Chronic Pain Medical Treatment Guidelines, Chronic Pain Section, page 122 Page(s): 122.

Decision rationale: This patient presents with pains that include migraines and cervical-lumbar pain, pain in the limb, and foot and ankle problems. They requested for periodic trigger point injections. Treating physician's reports 07/11/2013 states that trigger point injections improved pain by 50% lasting a couple of months. Each of the reports by [REDACTED] on numerous occasions has documentation that trigger point injections help for neck and headaches. However, none of the reports described exactly where the injections are provided or which muscles and which trigger points. None of the reports by [REDACTED] or [REDACTED] described specific trigger points. MTUS Guidelines page 122 have very specific requirements for trigger point injection. One of these requirements is documentation of "circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain." In this case, none of the reports described the specific findings. Furthermore, repeat injections are not recommended unless 50% reduction of pain relief is obtained for 6 weeks following an injection and there is documented evidence of functional improvement. In this patient, functional improvements are documented with the use of medications and some of the procedures that are provided, and the treater indicates the patient experiences greater than 50% reduction of pain in the neck and headaches lasting for 2 months. However, physical examinations do not document exactly where the trigger points are. Furthermore, the request does not mention how many trigger points are to be injected. MTUS Guidelines limit no more than 3 to 4 injections per session. Furthermore, the request for periodic trigger point injections cannot be authorized as injection should be done one set at a time. The request for periodic trigger point injections, up to four per year, is not medically necessary or appropriate.

HYDROXYZINE 25MG: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

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

Decision rationale: This patient presents with widespread pain including neck, headaches, low back pain, and radiculopathy. There is a request for hydroxyzine 25 mg. MTUS and ACOEM Guidelines do not discuss hydroxyzine. However, ODG Guidelines supports the use of hydroxyzine for situations of anxiety and chronic pain, and also for weaning opiates. In this patient, anxiety is not one of the listed diagnoses. None of the reports discuss that this patient is struggling with anxiety, although there are reports of depression. Use of this medication may be appropriate given the patient's chronic pain, depression, and likely anxiety which is not well-documented. However, MTUS Guidelines page 8 requires that physicians provide monitoring of treatments. MTUS Guidelines page 60 also requires that for each medications using chronic pain, pain assessment and function need to be documented. In this case, none of the reports reviewed discussed the specific effectiveness of hydroxyzine. It is not known whether or not this

medication is doing anything for this patient. The request for Hydroxyzine 25 mg is not medically necessary or appropriate.

NEXIUM 40MG, #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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MTUS Chronic Pain Medical Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs), G.

Decision rationale: This patient presents with chronic pain. There is a request for Nexium. MTUS Guidelines support use of Nexium for prophylactic use when NSAIDs are used on a chronic basis. GI risk assessment needs to be provided. In this patient, review of the reports provides documentation that this patient is on Motrin on high dose at 3 times a day. Treating physician's report 01/21/2013 documents chronic ulcer and stomach issues. Given the patient's high-dose Motrin, use of Nexium is supported by MTUS Guidelines. The request for Nexium 40 mg, thirty count, is medically necessary and appropriate.

TYLENOL WITH CODEINE (#4), #200: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MTUS Chronic Pain Medical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MTUS Chronic Pain Medical Treatment Guidelines, Guidelines on Long-term Opioid Use Section, page.

Decision rationale: This patient presents with chronic pain. The request is for Tylenol No. 4. There appears to be adequate documentation for use of opiates in this patient. The patient suffers from moderate to severe pain, and treating physicians both [REDACTED] and [REDACTED] provide adequate documentation regarding the patient's level that are consistently reduced with use of medications. Use of numeric scales is provided. Functional measures are also mentioned, say for example, treating physician's report September 18, 2013, documents the patient's walking, improved function with use of medications, attends chiropractics, putting aside food, et cetera. MTUS Guidelines for chronic opiates require use of numeric scale to denote function and pain, documentation of 4 A's including analgesia, activities of daily living, adverse effects, adverse behavior. In this case, these requirements appear to be satisfied. The request for Tylenol with Codine (Tylenol #4), 200 count, is medically necessary and appropriate.

CLONIDINE 1MG, #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MTUS Chronic Pain Medical Treatment Guidelines, Clonidine - Intrathecal Section, pages 34 - 35 P.

Decision rationale: This patient presents with chronic pain syndrome with pains in the neck, low back, upper and lower extremities. The request is for clonidine. The Chronic Pain Medical Treatment Guidelines discusses clonidine in the context of intrathecal delivery system which is not relevant to this patient. The Chronic Pain Medical Treatment Guidelines also discusses use of clonidine for CRPS (chronic regional pain syndrome) and ODG Guidelines also discuss use of clonidine in the context of CRPS and intrathecal delivery system. This patient does not present with CRPS, nor does she have intrathecal delivery system. Despite review of 2013 reports from [REDACTED] and [REDACTED], there is not a discussion regarding why this medication is prescribed. The Chronic Pain Medical Treatment Guidelines require that the physician provide monitoring and appropriate changes in treatment recommendations. The Chronic Pain Medical Treatment Guidelines also requires documentation of pain and function for use of medication for chronic pain. In this case, there is no discussion regarding use of clonidine, what it is used for, and for what purpose. Furthermore, there is lack of support in the guidelines for use of this medication in chronic pain. The request for Clonidine 1 mg, 30 count is not medically necessary or appropriate.

LUNESTA 2MG, #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

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

Decision rationale: This patient presents with chronic pain and insomnia as documented in multiple reports. There is a request for Lunesta. MTUS and ACOEM Guidelines do not discuss Lunesta, but ODG Guidelines discuss Lunesta under insomnia and states, "Lunesta has demonstrated reduced sleep latency and sleep maintenance. The only benzodiazepine receptor agonist FDA approved for use longer than 35 days." The request for Lunesta 2 mg, 30 count, is medically necessary and appropriate.

REPEAT RFA (RADIO FREQUENCY ABLATION) / RHIZOTOMY / S1 JOINT INJECTION: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Guidelines on Radiofrequency Ablation Chapter, Lumbar Spine Section

Decision rationale: This patient presents with chronic low back pain. Patient is status post radiofrequency ablation from January 2013. There is a request for repeat RFA. Review of the

reports show that following the radiofrequency rhizotomy from 01/29/2013, there is a progress report 02/28/2013 discussing the results. This report under treatment discussion states "70% better" and that the patient was thrilled from radiofrequency ablation. However, under subjective, it states that the patient still suffers from moderate to severe pain. With medications, pain subsides to only 6/10 from 8/10. The list of medications showed no changes when compared to list of medications from 01/21/2013. While the treating physician believes that this patient is 70% better, there are no documentations to validate this claim. Furthermore, [REDACTED] discusses radiofrequency ablation results on her report 07/11/2013. It states that the patient experienced about 2½ months of lumbar spine pain reduction following radiofrequency ablation. MTUS Guidelines does not discuss radiofrequency ablation. ACOEM Guidelines does not discuss repeat radiofrequency ablation. ODG Guidelines has specific discussion regarding repeat rhizotomies. It states that the procedure should not occur at an interval less than six months from the first procedure, and the first procedure should document improvement for at least twelve weeks at greater than 50% reduction of pain and that the procedure should not be repeated unless there is a sustained pain relief generally of at least 6 months duration. Approval of repeat neurotomies depend on documentation of visual analog scale score, decreased medication and documented improvement in function. Although the patient subjectively reports 70% better, review of the documentations does not show significant change in the patient's visual analog scale, no changes in function other than the improved function she typically derives from use of medication. Duration of relief appears to have been about 2½ months which is shy of the required 6 months reduction of pain per ODG Guidelines. The request for a repeat radiofrequency ablation/rhizotomy/S1 joint injection is not medically necessary or appropriate.

BOTOX INJECTION FOR HA (HEADACHE): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MTUS Chronic Pain Medical Treatment Guidelines, Botulinum toxin (B.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MTUS Chronic Pain Medical Treatment Guidelines, Botulinum toxin (Botox®; Myobloc®) Section, pa.

Decision rationale: This patient presents with chronic headaches of migrainous type. The treating physician is requesting Botox injection for headaches. Review of the reports show that the patient has had multiple Botox injections in the past with documentation of pain reduction. For example, the treater's report indicates that Botox injections help with headaches and decreases the migrainous attacks down to 1 attack per month. It also helped to decrease use of Demerol. Botox injections were provided in January 2013 and June of 2013. Unfortunately, the Chronic Pain Medical Treatment Guidelines does not support use of Botox injections for "migraine headaches." The Chronic Pain Medical Treatment Guidelines also states "not recommended for the following: Tension-type headaches; migraine headache; fibromyositis; chronic neck pain; myofascial pain syndrome; and trigger point injections." The request for Botox injections for headache si not medically necessary or appropriate.