

<b>Case Number:</b>	CM14-0000792		
<b>Date Assigned:</b>	01/17/2014	<b>Date of Injury:</b>	09/08/2003
<b>Decision Date:</b>	06/27/2014	<b>UR Denial Date:</b>	12/21/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/02/2014

### 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 Anesthesiology, 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:

The patient is a 52-year-old male who has submitted a claim for other back symptoms associated with an industrial injury date of September 8, 2003. The patient complains of chronic neck and low back pain rated 9/10. Current medications include Flexeril, Pamelor, and Terocin. GI upset was reported from Flexeril and Pamelor. Physical examination showed a mildly antalgic gait; limitation of motion of the cervical and lumbar spine; positive facet loading at the right C4-5, C5-6, C6-7; positive muscle spasm in the bilateral paralumbar muscles with positive twitch response and referred pain to the thoracic region; and diminished sensation at the left C5, C6, C7 and C8 and right L5 and S1 dermatomes. The diagnoses include facet arthropathy; lumbar radiculopathy; lumbar stenosis; degenerative disc disease of the cervical spine; cervical stenosis; cervical radiculopathy; chronic pain syndrome; degenerative disc disease of the lumbar spine, status post microlumbar decompressive surgery and failed back syndrome. The patient was also diagnosed with depression, fatty liver disease and GERD based on a progress report dated December 13, 2013. The current treatment plan includes a request for Indomethacin 25mg #30 with refills and trigger point injections into the bilateral lumbar paravertebral musculature. Treatment to date has included oral and topical analgesics, muscle relaxants, AEDs, medical marijuana, chiropractic care, epidural injections, home exercise program, physical therapy, acupuncture and spine surgery. Utilization review from December 20, 2013 denied the request for 1 prescription of Indomethacin 25mg #30 with refills due to medical history of fatty liver disease and GERD; and 1 trigger point injection into the bilateral lumbar paravertebral musculature due to the diagnosis of lumbar radiculopathy in this patient.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**INDOMETHACIN 25MG #30 WITH 5 REFILLS:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, NSAIDS,

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines 2009 Page(s): 46.

**Decision rationale:** Page 46 of the CA MTUS Chronic Pain Medical Treatment Guidelines recommends NSAIDs with caution in patients with moderate hepatic impairment and not recommended for patients with severe hepatic impairment. In this case, the patient was diagnosed with fatty liver disease along with the complaints of chronic neck and back pain. There were no available liver function tests to determine the extent of the hepatic impairment in this patient. Moreover, he was also diagnosed with GERD and reports adverse GI symptoms from other pain medications. Intake of non-selective NSAIDs may aggravate his present GI complaints. It was also noted on a progress report dated July 30, 2013 that the patient was prescribed with Indomethacin. However, there was no documentation of overall pain improvement and functional gains from its use. The medical necessity has not been established. There was no compelling rationale concerning the need for variance from the guidelines. Therefore, the request for INDOMETHACIN 25MG #30 WITH 5 REFILLS is not medically necessary.

**1 TRIGGER POINT INJECTION INTO THE BILATERAL LUMBAR PARAVERTEBRAL MUSCULATURE:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, ,

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines 2009 Page(s): 122.

**Decision rationale:** Page 122 of the CA MTUS Chronic Pain Medical Treatment Guidelines state that trigger point injections are recommended for myofascial pain syndrome only. It is not recommended for radicular pain. Criteria for the use of trigger point injections include documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain; and failure of medical management therapies to control pain such as ongoing stretching exercises, physical therapy, NSAIDs and muscle relaxants. In this case, the patient has been diagnosed with lumbar radiculopathy corroborated by lumbar MRI back in March 2012. The guideline does not support trigger point injections in patients with radicular pain. Moreover, there was no objective evidence of failure of conservative management to control the pain. There was no compelling rationale concerning the need for variance from the

guidelines. Therefore, the request for 1 TRIGGER POINT INJECTION INTO THE BILATERAL LUMBAR PARAVERTEBRAL MUSCULATURE is not medically necessary.