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| Case Number: | CM14-0120572 | | |
| Date Assigned: | 08/06/2014 | Date of Injury: | 05/18/2010 |
| Decision Date: | 10/02/2014 | UR Denial Date: | 07/11/2014 |
| Priority: | Standard | Application Received: | 07/30/2014 |

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 Family Medicine 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 is a 50-year-old male patient who reported an industrial injury on 5/18/2010, over four (4) years ago, attributed to the performance of his usual and customary job tasks. The patient was noted to complain about the in right trapezius region pain of severe intensity. The objective findings on examination included limited and restricted cervical spine range of motion; trigger points in the posterior cervical musculature the right levator scapula and persistent right volar wrist tenderness with a positive Tinel's test. The patient has indicated that there is no change with continued pain. The patient was noted to have had trigger point injections administered to the cervical thoracic region on 3/31/2014. The patient was reported to have chronic neck and upper back pain along with history of anxiety, depression, and decreased libido. The patient had been on chronic opioid therapy. The patient was prescribed Opana ER 7.5 mg #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Opana ER 7.5 mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Long time users of Opioids.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-306, Chronic Pain Treatment Guidelines opioids Page(s): 74-97. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine

(ACOEM), 2ndEdition, (2004) chapter 6 pages 114-116; Official Disability Guidelines (ODG) pain chapter opioids

Decision rationale: The prescription for Opana ER 7.5 mg #60 for long-acting pain is being prescribed as an opioid analgesic for the treatment of chronic pain to the upper back/neck for the date of injury four (4) years ago. The objective findings on examination do not support the medical necessity for continued opioid analgesics. The patient is being prescribed opioids for neck and upper back pain, which is inconsistent with the recommendations of the CA MTUS. There is no objective evidence provided to support the continued prescription of opioid analgesics for the cited diagnoses and effects of the industrial claim. The patient should be titrated down and off the prescribed Opioids. There is no demonstrated medical necessity for the continuation of opioids for the effects of the industrial injury. The patient is not documented to have received any functional benefit from the prescribed Opana ER. The chronic use of Opana ER 7.5 mg is not recommended by the MTUS, the ACOEM Guidelines, or the Official Disability Guidelines for the long-term treatment of chronic back, shoulder or knee pain. The prescription of opiates on a continued long-term basis is inconsistent with the MTUS and the Official Disability Guidelines recommendations for the use of opiate medications for the treatment of chronic pain. There is objective evidence that supports the use of opioid analgesics in the treatment of this patient over the use of NSAIDs for the treatment of chronic pain. The current prescription of opioid analgesics is inconsistent with evidence-based guidelines. The prescription of opiates on a continued long-term basis is inconsistent with the Official Disability Guidelines recommendations for the use of opiate medications for the treatment of chronic pain. There is objective evidence that supports the use of opioid analgesics in the treatment of this patient over the use of NSAIDs for the treatment of chronic pain issues. Evidence-based guidelines necessitate documentation that the patient has signed an appropriate pain contract, functional expectations have been agreed to by the clinician, and the patient, pain medications will be provided by one physician only, and the patient agrees to use only those medications recommended or agreed to by the clinician to support the medical necessity of treatment with opioids. The ACOEM Guidelines updated chapter on chronic pain states Opiates for the treatment of mechanical and compressive etiologies: rarely beneficial. Chronic pain can have a mixed physiologic etiology of both neuropathic and nociceptive components. In most cases, analgesic treatment should begin with acetaminophen, aspirin, and NSAIDs (as suggested by the WHO step-wise algorithm). When these drugs do not satisfactorily reduce pain, opioids for moderate to moderately severe pain may be added to (not substituted for) the less efficacious drugs. A major concern about the use of opioids for chronic pain is that most randomized controlled trials have been limited to a short-term period (70 days). This leads to a concern about confounding issues; such as, tolerance, opioid-induced hyperalgesia, long-range adverse effects, such as, hypogonadism and/or opioid abuse, and the influence of placebo as a variable for treatment effect. The ACOEM guidelines state that opioids appear to be no more effective than safer analgesics for managing most musculoskeletal symptoms; they should be used only if needed for severe pain and only for a short time. The long-term use of opioid medications may be considered in the treatment of chronic musculoskeletal pain, if: The patient has signed an appropriate pain contract; Functional expectations have been agreed to by the clinician and the patient; Pain medications will be provided by one physician only; The patient agrees to use only those medications recommended or agreed to by the clinician. ACOEM also notes, "Pain medications are typically not useful in the subacute and chronic phases and have been shown to be the most important factor impeding recovery of function. There is no clinical documentation by with objective findings on examination to support the medical necessity of Opana ER 7.5 mg for this long period of time or to support ongoing functional improvement. There is no provided evidence that the patient has received benefit or demonstrated functional improvement with the

prescribed Opana ER 7.5 mg. There is no demonstrated medical necessity for the prescribed Opioids. The prescription for Opana ER 7.5 mg #60 is not medically necessary.

2 Trigger point injections: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): Pages 174 and 175. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back (Acute and Chronic)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter-trigger point injections

Decision rationale: The objective findings documented did not meet the criteria recommended by the MTUS and the ACOEM Guidelines for the use of TPIs for chronic back, shoulder or neck pain. There is no demonstrated medical necessity for prn trigger point injections to the objective findings that included spasm and TTP documented on examination. The medical records submitted for review fail to document any red flags or significant functional objective deficits that would preclude the patient from being able to participate in an independent home exercise program. The patient should be placed on active participation in an independently applied home exercise program consisting of stretching, strengthening, and range of motion exercises. The use of trigger point injections are recommended for the treatment of chronic back, neck, or shoulder pain in certain conditions when trigger points are identified with a myofascial pain syndrome as a secondary or tertiary treatment in conjunction with an active defined program for rehabilitation when the patient is demonstrated not to be improving with conservative treatment. The MTUS and the Official Disability Guidelines state, Trigger point injections with an anesthetic such as bupivacaine are recommended for non-resolving trigger points, but the addition of a corticosteroid is not generally recommended. 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. The MTUS and the Official Disability Guidelines recommend the use of trigger point injections for chronic low back or neck pain with myofascial pain syndrome when all of 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 with reduced medication use 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; (9) There should be evidence of continued ongoing conservative treatment including home exercise and stretching. Use as a sole treatment is not recommended; (10) If pain persists after 2 to 3 injections the treatment plan should be reexamined as this may indicate an incorrect diagnosis, a lack of success with this procedure, or a lack of incorporation of other more conservative treatment modalities for myofascial pain. It should be remembered that trigger point injections are considered an adjunct, not a primary treatment. The MTUS and the Official Disability Guidelines do not recommend the use of trigger point injections in the absence of myofascial pain syndromes, without documentation of circumscribed trigger points, or without an ongoing active rehabilitation program. There is no provided documentation consistent with myofascial pain or documented trigger points with muscle fasciculation in the clinical narrative. The

patient's documented diagnoses do not include myofascial pain syndrome and there are no defined specific trigger points and other conservative treatment has not been attempted. There was no demonstrated medical necessity. Therefore, 2 Trigger point injections is not medically necessary.