

Case Number:	CM14-0180003		
Date Assigned:	11/04/2014	Date of Injury:	10/13/2003
Decision Date:	12/10/2014	UR Denial Date:	09/27/2014
Priority:	Standard	Application Received:	10/29/2014

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 Occupational Medicine and is licensed to practice in Montana. 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 injured worker is a cemented mason with a date of injury 10/13/03 when he was involved in a motor vehicle accident. He was initially hospitalized for one week and had surgery on the right hip. She has not worked since the injury. At this time he complains of continuing neck, right shoulder and right hip pain. Medications have included Norco, Fexmid, Prilosec, Xanax, nonsteroidal anti-inflammatory medication, and Neurontin. He has had lumbar epidural steroid injections and multiple trigger point injections which appear to be in the posterior cervical region. His current diagnoses include right hip pain status post ORIF, bilateral lower extremity neuropathic pain, positive discogram findings at L1-S1, medication-induced gastritis, right knee internal derangement, implantation of spinal cord stimulator for chronic low back pain and hypogonadism secondary to chronic opiate use. There is no diagnosis of myofascial pain although examination does describe myofascial pain with specific trigger points noted in the posterior cervical area. The treating physician has requested retrospective approval for Fexmid 7.5 mg #60, Norco 10/325 #240, and trigger point injections.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective: 4 Trigger point injections to right hip: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger Point Injections.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174-175, Chronic Pain Treatment Guidelines Trigger Point Injections Page(s): 122.

Decision rationale: The MTUS notes that invasive techniques (e.g., needle acupuncture and injection procedures, such as injection of trigger points, facet joints, or corticosteroids, lidocaine, or opioids in the epidural space) have no proven benefit in treating acute neck and upper back symptoms. However, many pain physicians believe that diagnostic and/or therapeutic injections may help patients presenting in the transitional phase between acute and chronic pain. The Chronic Pain Medical Treatment Guidelines recommend trigger point injections only for myofascial pain syndrome as indicated below, with limited lasting value. Not recommended for radicular pain. 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. Trigger points may be present in up to 33-50% of the adult population. Myofascial pain syndrome is a regional painful muscle condition with a direct relationship between a specific trigger point and its associated pain region. These injections may occasionally be necessary to maintain function in those with myofascial problems when myofascial trigger points are present on examination. Not recommended for typical back pain or neck pain. Criteria for the use of Trigger point injections: Trigger point injections with a local anesthetic may be recommended for the treatment of 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 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. (Colorado, 2002) (BlueCross BlueShield, 2004) In this case the treatment records note that trigger point injections have been given at a frequency of approximately 1 month or less. The records document improvement for approximately 2 weeks, not for 6 weeks as described in the MTUS criteria. The medical records note that the patient has requested repeat injections at each visit for the neck. The treating physician has noted myofascial pain in the posterior cervical, lumbar and right hip musculature. The injections provided are assumed to be posterior cervical however, the treatment note does not specify location. The request for retrospective, 4 trigger point injections to the right hip is not medically necessary.

Retrospective: 1 prescription of Fexmid 7.5mg, #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-spasmodics, Cyclobenzaprine Page(s): 64.

Decision rationale: The MTUS notes that Cyclobenzaprine (Fexmid) is an antispasmodic medication, recommended for a short course of therapy with the greatest benefit occurring within the first 4 days. Fexmid is not recommended to be used for longer than 2-3 weeks. The medical records indicate continuous use of Fexmid since at least January 2014. The continued use of cyclobenzaprine is not consistent with the MTUS guidelines. The retrospective request for Fexmid 7.5 mg #60 is not medically necessary.

Retrospective: 1 prescription of Norco 10/325mg, #240: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 75-78, 91.

Decision rationale: Norco is a brand name for hydrocodone, a short-acting opioid analgesic, combined with acetaminophen. The MTUS states that opioids are not recommended as first line therapy for neuropathic pain. Opioids are suggested for neuropathic pain that has not responded to first line recommendations including antidepressants and anticonvulsants. The MTUS states that reasonable alternatives to opioid use should be attempted. There should be a trial of non-opioid analgesics. When subjective complaints do not correlate with clinical studies a second opinion with a pain specialist and a psychological assessment should be obtained. The lowest possible dose should be prescribed to improve pain and function. Hydrocodone has a recommended maximum dose of 60mg/24 hours. Ongoing use of hydrocodone/acetaminophen requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: the least reported pain over the period since the last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. The medical records do document decrease in pain level and some functional improvement associated with his total treatment regimen. Side effects are documented, specifically hypogonadism associated with chronic opioid use. The least reported pain over the period since the last assessment; average pain, intensity of pain after taking the opioid, how long it takes for pain relief, and how long pain relief lasts is not documented. There has not been any documented attempt to decrease or wean opioid medication over time. The current request is for Norco 10/325, 8/day. This exceeds the maximum recommended dose of hydrocodone of 60 mg/day. The request for Norco (hydrocodone/acetaminophen) 10/325 #240 is not medically necessary.