

<b>Case Number:</b>	CM14-0198501		
<b>Date Assigned:</b>	12/08/2014	<b>Date of Injury:</b>	02/23/2000
<b>Decision Date:</b>	01/21/2015	<b>UR Denial Date:</b>	10/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/24/2014

### 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 Neurology, has a subspecialty in Neuromuscular Medicine and is licensed to practice in New Jersey. 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 57-year-old man who sustained a work-related injury on February 23, 2000. Subsequently, the patient developed a chronic neck and back pain for which she underwent the cervical and lumbar fusion. According to a progress report dated on October 9, 2014, the patient was complaining of ongoing back and neck pain. The patient physical examination demonstrated cervical tenderness with reduced range of motion and lumbar tenderness. The patient was diagnosed with state post lumbar and cervical fusion. The patient was treated with pain medications without pain control. The provider requested authorization for trigger point injections and shockwave therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retro: Trigger Point Injections To Lumbar Dos 10/09/14: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Trigger point injections Page(s): 122.

**Decision rationale:** According to California MTUS guidelines, trigger point injection is recommended 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. (Graff-Radford, 2004) (Nelemans-Cochrane, 2002) For fibromyalgia syndrome, trigger point injections have not been proven effective. (Goldenberg, 2004) 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. There is no clear evidence of myofascial pain and trigger points over the lumbar paraspinal musculature. There is no documentation of failure of oral medications or physical therapy in this case. Therefore, the request for trigger point injections to lumbar DOS 10/09/14 is not medically necessary.

### **Shockwave Therapy To Bilateral Iliac Crest: 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 ACOEM Chapter 9 Shoulder Complaints Page(s): 203, Chronic Pain Treatment Guidelines Elbow Complaints; Extracorporeal Shockwave Therapy Page(s): 29.

**Decision rationale:** My rationale for why the requested treatment/service is or is not medically necessary: According to California MTUS guidelines, several studies evaluated the efficacy of extracorporeal shockwave therapy for the treatment of lateral epicondylitis (LE). These studies did not demonstrate its benefit for the management LE. There is no studies supporting its use for neck, shoulder and wrist pain. There is a some medium quality evidence supports manual physical therapy, ultrasound, and high energy extracorporeal shock wave therapy for calcifying tendinitis of the shoulder. There is no documentation of shoulder tendinitis in this case and there is no justification for the use of this procedure for shockwave therapy to bilateral iliac crest. Official Disability Guidelines (ODG) guidelines do not support the use of this procedure for iliac

crest pain therefore the prescription of shockwave therapy to bilateral iliac crest is not medically necessary.

**Norco 10/325 #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of opioids Page(s): 76-79.

**Decision rationale:** According to California MTUS guidelines, Norco (Hydrocodone/Acetaminophen) is a synthetic opioid indicated for the pain management but not recommended as a first line oral analgesic. In addition and according to California MTUS guidelines, ongoing use of opioids should follow specific rules:(a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy.(b) The lowest possible dose should be prescribed to improve pain and function.(c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework. According to the patient file, there is no objective documentation of pain and functional improvement to justify continuous use of Norco. Norco was used for longtime without documentation of functional improvement or evidence of improvement of activity of daily living. Therefore, the prescription of Norco 10/325 mg, #60 is not medically necessary.

**Ambien 10mg #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:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Non-Benzodiazepine sedative-hypnotics (Benzodiazepine-receptor agonists (<http://worklossdatainstitute.verioiponly.com/odgtwc/pain.htm>

**Decision rationale:** According to California MTUS guidelines, Flexeril a non-sedating muscle relaxants, is recommended with caution as a second line option for short term treatment of acute exacerbations in patients with chronic spasm and pain. Efficacy appears to diminish over time and prolonged use may cause dependence. There is no recent documentation of pain and spasticity improvement. Therefore the request for authorization Flexeril 10mg #60 is not medically necessary.

**Flexeril 10mg #60:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

**Decision rationale:** According to MTUS guidelines, Flexeril, a non sedating muscle relaxants, is recommended with caution as a second line option for short term treatment of acute exacerbations in patients with chronic spasm and pain. Efficacy appears to diminish over time and prolonged use may cause dependence. There is no recent documentation of pain and spasticity improvement. Therefore the request for authorization Flexeril 10mg #60 is not medically necessary.