

<b>Case Number:</b>	CM15-0134849		
<b>Date Assigned:</b>	07/23/2015	<b>Date of Injury:</b>	05/16/2012
<b>Decision Date:</b>	09/22/2015	<b>UR Denial Date:</b>	07/01/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/13/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

### 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 34-year-old female who sustained an industrial injury on 5/16/12. The injured worker was diagnosed as having chronic rotator cuff impingement, cervicobrachial syndrome, chronic myofascial pain syndrome and bicipital tenosynovitis. Currently, the injured worker was with complaints of bilateral shoulder pain with noted numbness and tingling and weakness from the forearms to the fingers. Previous treatments included rest, oral pain medication, benzodiazepine, activity modification. Previous diagnostic studies were not noted. The injured work status was noted as working with modifications. The injured workers pain level was noted as ranging from 0/10 to 7/10. Physical examination was notable for trigger points palpated in the splenius captious, upper and lower trapezius regions, and sternocleidomastoid area, positive crepitus with passive range of motion in bilateral shoulders, biceps tendon and acromioclavicular joint tenderness to palpation. The plan of care was for Hysingla 20 milligrams quantity of 30 and trigger point injection (bilateral shoulders).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Hysingla 20mg #30: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, Therapeutic Trial of Opioids; Opioids for chronic pain; Opioids for neuropathic pain Page(s): 76-80, 80-82, 82-83. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Hysingla (hydrocodone).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Section Page(s): 74-95, 124. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter/Hysingla (hydrocodone) Section.

**Decision rationale:** The MTUS Guidelines do not recommend the use of opioid pain medications, in general, for the management of chronic pain. There is guidance for the rare instance where opioids are needed in maintenance therapy, but the emphasis should remain on non-opioid pain medications and active therapy. Long-term use may be appropriate if the patient is showing measurable functional improvement and reduction in pain in the absence of non-compliance. Functional improvement is defined by either significant improvement in activities of daily living or a reduction in work restriction as measured during the history and physical exam. Per the ODG, Hysingla is not recommended for first-line use for treatment of acute or chronic non-malignant pain. Short-acting opioids are recommended prior to use of long-acting opioids. The FDA approved the extended-release (ER) single-entity opioid analgesic hydrocodone bitartrate (Hysingla ER, Purdue Pharma) with abuse-deterrent properties. Hysingla ER has properties that are expected to reduce, but not totally prevent, abuse of the drug when chewed and then taken orally, or crushed and snorted or injected. The product is indicated for treatment of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate. Opioids are not recommended as a first-line treatment for chronic non-malignant pain in ODG. In this case, although the injured worker has had a trial with a first line agent is not evident that all attempts at first-line agents have been trialed and failed. It is also not apparent that the injured worker needs round-the-clock, long-term opioid treatment. The request for Hysingla 20mg #30 is determined to not be medically necessary.

**Trigger point injection (bilateral shoulders):** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Trigger Point Injections Section Page(s): 122.

**Decision rationale:** The MTUS Guidelines recommend the use of trigger point injections for myofascial pain syndrome as indicated, with limited lasting value. It is 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. 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. Trigger point injections are not recommended for typical back pain or neck pain. For fibromyalgia syndrome, trigger point injections have not been proven effective. 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. In this case, there is documented objective circumscribed trigger points but there is no evidence of a twitch response. The request for trigger point injection (bilateral shoulders) is determined to not be medically necessary.