

Case Number:	CM15-0181382		
Date Assigned:	09/22/2015	Date of Injury:	11/12/2007
Decision Date:	11/18/2015	UR Denial Date:	08/25/2015
Priority:	Standard	Application Received:	09/15/2015

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: Arizona, Michigan

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 53 year old male who sustained an industrial injury on 11-12-2007. Physician impression was chronic pain, myofascial pain syndrome, and history of multiple rib fractures. Report dated 08-04-2015 noted that the injured worker presented with complaints that included back pain with associated numbness and tingling, and right inguinal pain. Pain level was 5-8 out of 10 on a visual analog scale (VAS). Physical examination performed on 08-04-2015 revealed increased bilateral neck pain with range of motion, tenderness in the left thoracic paraspinal area, bulging and hardening of musculature that is hypersensitive, taut band, and antalgic gait. Previous treatments included medications, trigger point injections, epidural steroid injection, and acupuncture. The physician noted that the last trigger point injection performed on 06-09-2015 was without steroid and lasted one week. The physician documented that the medications help to control pain and bring pain level down to 5 out of 10. The MS Contin was decreased but pain levels have increased again since acupuncture was last done 2 weeks ago. It was documented that acupuncture helped to decrease pain by 30%. The treatment plan included reducing MS Contin from three times per day to twice per day, refill Zanaflex, refilled nortriptyline, off Neurontin and other psychiatric medications due to no psychiatrist-psychologist appointment or care, request for additional acupuncture and trigger point injection, continue home exercise program, and follow up in one month. The injured worker has been prescribed Zanaflex since at least 11-25-2014. The utilization review dated 08-25-2015, non-certified the request for acupuncture x 12, MS Contin 15mg 1 by mouth every 8 hours #90, Zanaflex 4mg 1 by mouth at bedtime #30, and trigger point injection left med-thoracic paraspinal region (trigger

point injection x 3, three or more muscle groups, injections, single or multiple trigger points, 3 or more muscles.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture x 12: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment 2007.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment 2007.

Decision rationale: The MTUS recommends acupuncture as an option when pain medication is reduced or not tolerated, and it may be used as an adjunct to physical rehabilitation and or surgical intervention to hasten functional recovery. Acupuncture can be used to reduce pain, reduce inflammation, increase blood flow, increase range of motion, decrease the side effect of medication -induced nausea, promote relaxation in an anxious patient and reduce muscle spasm. Time to produce functional improvement is 3-6 treatments. 1-3 times a week for 1-2 months. This passive intervention should be an adjunct to active rehab efforts. ODG Acupuncture Guidelines: Initial trial of 3-4 visits over 2 weeks. With evidence of objective functional improvement, total of up to 8-12 visits over 4-6 weeks (Note: The evidence is inconclusive for repeating this procedure beyond an initial short course of therapy.) A review of the injured workers medical records show that he has already been authorized for 6 acupuncture visits, however it is unclear how many visits he has had and if he made any functional gains with the treatments, the request for an additional 12 visits exceeds guideline recommendations and is not medically necessary.

MS Contin 15mg 1 by mouth every 8 hours #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

Decision rationale: Per the MTUS, opioids should be discontinued if there is no overall improvement in function, unless there are extenuating circumstances, Opioids should be continued if the patient has returned to work or has improved functioning and pain. Ongoing management actions should include prescriptions from a single practitioner, taken as directed and all prescriptions from a single pharmacy. The lowest possible dose should be prescribed to improve pain and function. Documentation should follow the 4 A's of analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors. Long term users of opioids should be regularly reassessed. In the maintenance phase the dose should not be lowered if it is working. Also, patients who receive opioid therapy may sometimes develop unexpected changes in their response to opioids, which includes development of abnormal pain, change in pain pattern, persistence of pain at higher levels than expected when this happens opioids can actually

increase rather than decrease sensitivity to noxious stimuli. It is important to note that a decrease in opioid efficacy should not always be treated by increasing the dose or adding other opioids, but may actually require weaning. A review of the injured workers medical records reveal that his MS contin was being reduced from tid to bid, it is unclear why this request is for q8h, there is also inadequate documentation of improvement in pain and function as well as ongoing management actions as required by the guidelines, therefore the request for MS Contin 15mg 1 by mouth every 8 hours #90 is not medically necessary.

Zanaflex 4mg 1 by mouth at bedtime #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

Decision rationale: The MTUS recommends non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. (Homik, 2004) Sedation is the most commonly reported adverse effect of muscle relaxant medications. These drugs should be used with caution in patients driving motor vehicles or operating heavy machinery. Drugs with the most limited published evidence in terms of clinical effectiveness include chlorzoxazone, methocarbamol, dantrolene and baclofen. This medication is not recommended for long term use and there are no extenuating circumstances or documentation of pain or functional improvement that warrant continued use in the injured worker, therefore the request for Zanaflex is not medically necessary.

Trigger point injection left med-thoracic paraspinal region (trigger point injection x 3, three or more muscle groups, injection(s), single or multiple trigger point(s), 3 or more muscles(s).: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Trigger point injections.

Decision rationale: Per the MTUS, Trigger point injections are 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. 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. Per the MTUS, 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. The injured worker does not appear to have met the criteria for repeat injections, therefore the request for Trigger point injection left med-thoracic paraspinal region (trigger point injection x 3, three or more muscle groups, injection(s), single or multiple trigger point(s), 3 or more muscles(s) is not medically necessary.