

Case Number:	CM15-0211532		
Date Assigned:	10/30/2015	Date of Injury:	11/04/2010
Decision Date:	12/17/2015	UR Denial Date:	09/25/2015
Priority:	Standard	Application Received:	10/26/2015

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: Massachusetts

Certification(s)/Specialty: Anesthesiology, Pain Management

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 66 year old female, who sustained an industrial injury on 11-4-10. The documentation on 8-27-15 noted that the injured worker has complaints of neck dull and aching pain with associated headaches. The pain is rated at 7 out of 10 on the visual analog scale without medications and a 3-4 out of 10 with medications. The pain is aggravated by neck movements and is associated with radiating pain, numbness and tingling to both upper extremities more to the left side. The injured worker has complaints of loss of sleep due to pain and anxiety. There is tenderness and myospasm palpable over bilateral paracervical muscles and bilateral trapezius muscles. The spurlings and cervical distraction tests are bilaterally positive. There is decreased cervical range of motion, due to end range neck pain. The diagnoses have included cervical disc displacement with radiculopathy; cervical myositis, myalgia; cervical spinal stenosis; cervical radiculopathy and cervical spine sprain and strain. Treatment to date has included tramadol; naproxen; cyclobenzaprine; omeprazole; cervical epidural steroid injection; and topical cream. The original utilization review (8-27-15) non-certified the request for retrospective trigger point injections (paracervical muscles (date of service 8-27-15) (1 X 2); retrospective use of toradol 60mg intramuscular injection of the left gluteal musculature (date of service 8-27-15) and retrospective tramadol 37.5-325mg (date of service 8-27-15).

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Trigger point injections (paracervical muscles (DOS 8/27/15) (1 X 2):
Overturned

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

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

Decision rationale: According to 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. 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, trigger point injections have not been proven effective. (Goldenberg, 2004). 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) According to the documents available for review, the injured worker does have a trigger point of discreet focal tenderness located in a palpable top band of skeletal muscle, which produces a local twitch in response to stimulus to the band. Therefore, at this time the requirements for treatment have been met and medical necessity has been established; the request is medically necessary.

Retrospective use of Toradol 60mg IM injection of the left gluteal musculature (DOS 8/27/15): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, NSAIDs.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Toradol.

Decision rationale: The ODG state that toradol IM may be used as an alternative to opioid therapy. It should not be used for minor pain or for chronic painful conditions. According to the documents available for review, the IW carries the diagnoses of cervical disc displacement with radiculopathy; cervical myositis, myalgia; cervical spinal stenosis; cervical radiculopathy and cervical spine sprain and strain. These are chronic conditions and there is no rationale provided as to why Toradol would be needed. Therefore, the requirements for treatment have not been met and medical necessity has not been established; the request is not medically necessary.

Retrospective Tramadol 37.5/325mg (DOS 8/27/15): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain, Opioids for neuropathic pain.

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

Decision rationale: According to the MTUS Chronic Pain Medical Treatment Guidelines section on Opioids, On-Going Management, p 74-97, (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. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the injured worker's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the injured worker's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain injured workers 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 for documentation of the clinical use of these controlled drugs. (Passik, 2000) (d) Home: To aid in pain and functioning assessment, the injured worker should be requested to keep a pain dairy that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management. (e) Use of drug screening or in injured worker treatment with issues of abuse, addiction, or poor pain control. (f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion). (g) Continuing review of overall situation with regard to non-opioid means of pain control. (h) Consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve

on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Additionally, the MTUS states that continued use of opioids requires (a) the injured worker has returned to work, (b) the injured worker has improved functioning and pain. There is no current documentation of baseline pain, pain score with use of opioids, functional improvement on current regimen, side effects or review of potentially aberrant drug taking behaviors as outlined in the MTUS and as required for ongoing treatment. Therefore, at this time, the requirements for treatment have not been met and medical necessity has not been established; the request is not medically necessary.