

Case Number:	CM15-0211682		
Date Assigned:	10/30/2015	Date of Injury:	09/27/2001
Decision Date:	12/31/2015	UR Denial Date:	10/09/2015
Priority:	Standard	Application Received:	10/27/2015

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: New York
 Certification(s)/Specialty: Anesthesiology

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(n) 47 year old female, who sustained an industrial injury on 9-27-01. The injured worker was diagnosed as having lumbar radiculopathy, cervicgia and myalgia and myositis. Subjective findings (3-23-15, 6-17-15) indicated neck and back pain and arm pain with numbness into the thumbs. Objective findings (3-23-15, 6-17-15) revealed pain with cervical range of motion. As of the PR2 dated 10-5-15, the injured worker reports more pain in the neck, arms and low back. Objective findings include tenderness and spasms in the lumbar paraspinal muscles and pain with cervical range of motion. Current medications include Celebrex, Prevacid, Voltaren gel (since at least 6-17-15), Fioricet (since at least 3-23-15) and Skelaxin (since at least 3-23-15). Treatment to date has included physical therapy and a home exercise program. The Utilization Review dated 10-9-15, non-certified the request for trigger point injections x 6, Voltaren gel 1%, Fioricet tabs and Skelaxin 800mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

Trigger point injections Qty: 6: 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: According to California MTUS Guidelines, 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 on exam; 5) Not more than 3-4 injections per session; 6) No repeat injections unless greater than 50% pain relief is obtained for six weeks after an injection and there is documented evidence of functional improvement; 7) Frequency should be at an interval less than 2 months; 8) Trigger point injections with any substance other than local anesthetic with or without steroid are not recommended. There was no documentation provided indicating circumscribed trigger points with palpable twitch response and referred pain. Medical necessity for the requested injections has not been established. The requested trigger point injections are not medically necessary.

Voltaren gel 1%: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs), Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: According to the California MTUS guidelines, Voltaren (Diclofenac) gel is a topical non-steroidal anti-inflammatory drug (NSAID) used for the treatment of osteoarthritis and tendonitis, in particular, knee and elbow joints that are amenable to topical treatment. There is little evidence that supports topical NSAIDs as a treatment option for spine and shoulder conditions. It may also be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. The duration of effect is for a short-term use (4-12 weeks) with reported diminished effectiveness over time. There is little evidence to use topical NSAIDs for the treatment of osteoarthritis of the spine, hip, or shoulder. The only FDA-approved topical NSAIDs are Diclofenac formulations. All other topical NSAIDs are not FDA approved. In this case, the patient has used Voltaren 1% gel since at least 6/17/2015. However, it is not clear where the Voltaren gel is being applied. Medical necessity for the requested topical gel has been not established. The requested 1% Voltaren gel is not medically necessary.

Fioricet tabs (Butalbital-APAP-Caffeine): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Barbiturate-containing analgesic agents. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Barbiturate-containing analgesic agents (BCAs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Barbiturate-containing analgesic agents.

Decision rationale: Barbiturate-containing analgesic agents (BCAs) are not recommended for chronic pain. The potential for drug dependence is high and no evidence exists to show a clinically important enhancement of analgesic efficacy of BCAs due to the barbiturate constituents. Fioricet contains butalbital, tylenol, and caffeine. The literature reported that butalbital containing combination analgesics should be avoided in migraine headache management. When used, it should be closely monitored to avoid overuse and dependence. It is recommended to be used less than 10 days/month. According to the CA MTUS, all therapies are focused on the goal of functional restoration rather than merely the elimination of pain and assessment of treatment efficacy is accomplished by reporting functional improvement. In this case, the patient has used Fioricet since at least 3/23/2015. There is a lack of functional improvement with the treatment already provided. The treating physician did not provide sufficient evidence of improvement in the work status, activities of daily living, and dependency on continued medical care with use of Fioricet. Guidelines do not recommend BCAs for chronic pain. Medical necessity for the requested treatment has not been established. The requested medication is not medically necessary.

Skelaxin 800mg: 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): Metaxalone (Skelaxin), Muscle relaxants (for pain).

Decision rationale: Metaxalone (Skelaxin) is reported to be a relatively non-sedating muscle relaxant. The exact mechanism of action is unknown, but the effect is presumed to be due to general depression of the central nervous system. A hypersensitivity reaction (rash) has been reported. It is to be used with caution in patients with renal and/or hepatic failure. Skelaxin is recommended as a second-line option for short-term (less than two weeks) treatment of acute LBP and for short-term treatment of acute exacerbations in patients with chronic LBP. According to the CA MTUS guidelines, muscle relaxants are not considered any more effective than non-steroidal anti-inflammatory medications alone. In this case, the available records show that the patient has not shown a documented benefit or any functional improvement from prior Skelaxin use, since at least 3/23/2015. Medical necessity for this muscle relaxant has not been established. The requested medication is not medically necessary.