

Case Number:	CM15-0053866		
Date Assigned:	03/27/2015	Date of Injury:	09/26/1996
Decision Date:	05/06/2015	UR Denial Date:	02/20/2015
Priority:	Standard	Application Received:	03/20/2015

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: Internal 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 39 year old male who sustained an industrial injury on 9/26/96. The injured worker reported symptoms in the chest, neck and back. The injured worker was diagnosed as having contusion of the chest wall, cervicothoracic spine crush injury, chronic neck, chest, and shoulder and thoracic spine pain. Treatments to date have included Botox injections, oral pain medication, topical patches, home exercise program, acupuncture treatment, heat, stretching, activity modification, and epidural injections. Currently, the injured worker complains of pain in the chest, neck and back. The plan of care was for medication prescriptions and a follow up appointment at a later date.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycontin 80 mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 47-48, 181-183, 308-310, Chronic Pain Treatment Guidelines Opioids Page 74-96.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines address opioids. The lowest possible dose should be prescribed to improve pain and function. Frequent evaluation of clinical history and frequent review of medications are recommended. Periodic review of the ongoing chronic pain treatment plan for the injured worker is essential. Patients with pain who are managed with controlled substances should be seen regularly. 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 nonadherent) 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). American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 3 states that opioids appear to be no more effective than safer analgesics for managing most musculoskeletal symptoms. Opioids should be used only if needed for severe pain and only for a short time. ACOEM guidelines state that the long-term use of opioids is not recommended for neck and back conditions. Medical records document the long-term use of opioids. ACOEM guidelines indicate that the long-term use of opioids is not recommended for neck and back conditions. Per MTUS, the lowest possible dose of opioid should be prescribed. The primary treating physician's progress report dated 11-19-2014 documented a history of injury to the chest, clavicles, neck, and back on 9/26/96. No significant changes noted in the patient's physical examination in this follow-up visit. He is a moderately overweight male. He is not in acute distress. Pupils are equal, round and reactive to light and accommodation. There is no corneal abrasion noted. Sclera appears to be clear. Conjunctiva is normal. Patient is able to follow the object through six cardinal positions of gaze. Gait was non-antalgic. The primary treating physician's progress report dated 12-12-2014 documented a history of injury to the chest, clavicles, neck, and back on 9/26/96. No significant changes noted in the patient's physical examination in this follow-up visit. He is a moderately overweight male. He is not in acute distress. Pupils are equal, round and reactive to light and accommodation. There is no corneal abrasion noted. Sclera appears to be clear. Conjunctiva is normal. Patient is able to follow the object through six cardinal positions of gaze. Gait was non-antalgic. The primary treating physician's progress report dated 01-09-2015 documented a history of injury to the chest, clavicles, neck, and back on 9/26/96. No significant changes noted in the patient's physical examination in this follow-up visit. He is a moderately overweight male. He is not in acute distress. Pupils are equal, round and reactive to light and accommodation. There is no corneal abrasion noted. Sclera appears to be clear. Conjunctiva is normal. Patient is able to follow the object through six cardinal positions of gaze. Gait was non-antalgic. The primary treating physician's progress report dated 02-04-2015 documented a history of injury to the chest, clavicles, neck, and back on 9/26/96. No significant changes noted in the patient's physical examination in this follow-up visit. He is a moderately overweight male. He is not in acute distress. Pupils are equal, round and reactive to light and accommodation. There is no corneal abrasion noted. Sclera appears to be clear. Conjunctiva is normal. Patient is able to follow the object through six cardinal positions of gaze. Gait was non-antalgic. No musculoskeletal physical examination was documented in the progress reports dated 1/9/15, 2/4/15, 12/12/14, and

11/19/14. No tenderness was as documented in the progress reports dated 1/9/15, 2/4/15, 12/12/14, and 11/19 /14. Without a documented musculoskeletal physical examination, the request for Oxycontin is not supported by MTUS & ACOEM guidelines. Therefore, the request for Oxycontin is not medically necessary.

Soma 350 mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47-49, Chronic Pain Treatment Guidelines Carisoprodol (Soma) Page 29. Muscle relaxants Page 63-65.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses muscle relaxants. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) states that muscle relaxants seem no more effective than NSAIDs for treating patients with musculoskeletal problems, and using them in combination with NSAIDs has no demonstrated benefit. Muscle relaxants may hinder return to function by reducing the patient's motivation or ability to increase activity. Table 3-1 states that muscle relaxants are not recommended. Chronic Pain Medical Treatment Guidelines (Page 63-66) address muscle relaxants. Muscle relaxants should be used with caution as a second-line option for short-term treatment. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. According to a review in American Family Physician, muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. MTUS Chronic Pain Medical Treatment Guidelines state that Carisoprodol (Soma) is not recommended. This medication is not indicated for long-term use. Medical records indicate the long-term use of Soma (Carisoprodol), which is not supported by MTUS guidelines. MTUS Chronic Pain Medical Treatment Guidelines state that Soma (Carisoprodol) is not recommended. MTUS and ACOEM guidelines do not support the use of Soma (Carisoprodol). Therefore, the request for Soma (Carisoprodol) is not medically necessary.

Unknown trigger point injections at the right lower neck and trapezius: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger point injections.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 174-175, 300, 309, Chronic Pain Treatment Guidelines Trigger point injections Page 122. Decision based on Non-MTUS Citation Work Loss Data Institute. Neck and upper back (acute & chronic). Encinitas (CA): Work Loss Data Institute; 2013 May 14. <http://www.guideline.gov/content.aspx?id=47589>.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines states that trigger point injections have limited lasting value. 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). American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 8 Neck and Upper Back Complaints indicates that injection of trigger points have no proven benefit in treating acute neck and upper back symptoms. Work Loss Data Institute guidelines for the neck and upper back (acute & chronic) states that trigger point injections are not recommended. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 12 Low Back Complaints (Page 300) indicates that trigger-point injections are not recommended. Invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. Table 12-8 Summary of Recommendations for Evaluating and Managing Low Back Complaints (Page 309) indicates that trigger-point injections are not recommended. The primary treating physician's progress report dated 01-09-2015 documented a history of injury to the chest, clavicles, neck, and back on 9/26/96. No significant changes noted in the patient's physical examination in this follow-up visit. He is a moderately overweight male. He is not in acute distress. Pupils are equal, round and reactive to light and accommodation. There is no corneal abrasion noted. Sclera appears to be clear. Conjunctiva is normal. Patient is able to follow the object through six cardinal positions of gaze. Gait was non-antalgic. There was no documentation of circumscribed trigger points with evidence upon palpation of a twitch response and referred pain on physical examination in the progress reports dated 1/9/15, 2/4/15, 12/12/14, and 11/19/14. Without documentation of trigger points on physical examination, the request for trigger point injections is not supported. Therefore, the request for trigger point injections is not medically necessary.