

Case Number:	CM15-0056383		
Date Assigned:	04/01/2015	Date of Injury:	01/07/2010
Decision Date:	05/27/2015	UR Denial Date:	03/19/2015
Priority:	Standard	Application Received:	03/24/2015

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 58 year old male, who sustained an industrial injury on 1/7/10. The diagnoses have included chronic neck pain, chronic musculoskeletal myofascial strain, cervical post laminectomy syndrome and chronic radiculopathy. Treatment to date has included medications, surgery, trigger point injections, acupuncture, and Home Exercise Program (HEP). Surgery included cervical fusion. The current medications included Amrix and Topamax. Currently, as per the physician progress note dated 2/24/15, the injured worker states that he has significant relief of pain with medications. He has also been participating in an independent rehabilitation program. Physical exam revealed tenderness to palpation of the upper trapezius and levator muscle complex bilaterally, weight was 137 pounds, heart rate was slightly tachycardic at 110 and blood pressure was 150/80. The physician recommended repeat trigger point injections in the upper trapezius and levator muscle complex, wean the medications, and monitor his condition over time. The physician requested treatments included 6 Visits of acupuncture, Medication management, Amrix 15 mg #60, Retrospective (DOS: 02/24/2015) Trigger point injections performed of the bilateral upper trapezius and levator muscle complex, right cervical paravertebral muscle and nerve and Retrospective (DOS: 02/24/2015) Suboccipital nerve block.

IMR ISSUES, DECISIONS AND RATIONALES

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

6 Visits of acupuncture: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Acupuncture Page(s): 13.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic). Acupuncture.

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. Per the ODG acupuncture is not recommended for neck pain. Despite substantial increases in its popularity and use, the efficacy of acupuncture for chronic mechanical neck pain still remains unproven. Acupuncture reduces neck pain and produces a statistically, but not clinically, significant effect compared with placebo. 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 reveal that he has pursued acupuncture independently with documentation of pain and functional improvement and a reduction in medication usage, therefore based on the injured workers clinical presentation and the guidelines the request for 6 visits of acupuncture is medically necessary.

Medication management: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Chapter 7 Independent Medical Examinations and Consultations, page 127.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper back (Acute and Chronic) / office visits.

Decision rationale: Per the MTUS/ ACOEM "Patients whose neck problems may be work related should receive follow-up care every three to five days by a midlevel practitioner, who can counsel them about avoiding static positions, medication use, activity modification, and other concerns. Take care to answer questions and make these sessions interactive so that patients are fully involved in their recovery. If the patient has returned to work, these interactions may be done on site or by telephone to avoid interfering with modified- or full-work activities. Physician follow-up generally occurs when a release to modified, increased, or full duty is needed, or after appreciable healing or recovery can be expected, on average. Physician follow-up might be

expected every four to seven days if the patient is off work and every seven to fourteen days if the patient is working. Per the ODG, office visits are "recommended as determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible." Therefore based on the injured workers clinical presentation and the guidelines the request for office visits for medication management is medically necessary.

Amrix 15 mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 41-42.

Decision rationale: Per the MTUS, Cyclobenzaprine is recommended as an option in the treatment of chronic pain using a short course of therapy. It is more effective than placebo in the management of back pain, the effect is modest and comes at the price of greater adverse effects. The effect is greatest in the first 4 days of treatment suggesting that shorter courses may be better. Treatment should be brief. This medication is only recommended to be used for 2-3 weeks. A review of the injured workers medical records reveal that he has been on Amrix for longer than 3 weeks which is not consistent with the guideline recommendations, therefore the continued use of Amrix is not medically necessary.

Retrospective (DOS: 02/24/2015) Trigger point injections performed of the bilateral upper trapezius and levator muscle complex, right cervical paravertebral muscle and nerve:
Overturned

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

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

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. A review of the injured workers medical records reveal documentation of pain and functional improvement with previous trigger point injections and the continued use of trigger point injections is medically necessary in the injured worker.

Retrospective (DOS: 02/24/2015) Suboccipital nerve block: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Head, Greater occipital nerve block.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic) / Greater occipital nerve block, therapeutic.

Decision rationale: The MTUS/ ACOEM did not specifically address the use of occipital nerve blocks and therefore other guidelines were consulted. Per the ODG, they are under study for treatment of occipital neuralgia and cervicogenic headaches. There is little evidence that the block provides sustained relief, and if employed, is best used with concomitant therapy modulations. Current reports of success are limited to small, non-controlled case series. Although short-term improvement has been noted in 50-90% of patients, many studies only report immediate post-injection results with no follow-up period. In addition, there is no gold-standard methodology for injection delivery, nor has the timing or frequency of delivery of injections been researched. Limited duration of effect of local anesthetics appears to be one factor that limits treatment and there is little research as to the effect of the addition of corticosteroid to the injectate. A review of the injured workers medical records reveal that the suboccipital block was done in conjunction with other treatment modalities, there is

documentation that he has had pain and functional improvement with other injections in the past and therefore the retrospective request for suboccipital nerve block is medically necessary.