

Case Number:	CM14-0214744		
Date Assigned:	01/07/2015	Date of Injury:	03/27/2002
Decision Date:	02/28/2015	UR Denial Date:	11/25/2014
Priority:	Standard	Application Received:	12/22/2014

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 Jersey, Michigan, California
 Certification(s)/Specialty: Neurology, Neuromuscular 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 patient is a 33-year-old man who sustained a work related injury on March 27, 2002. Subsequently, he developed chronic low back pain. According to a progress report dated November 19, 2014, the patient continued with his opioid medication management along with his Flexeril. he continued to work full full time. He has had his Gabapentin authorized and has reduced Oxycontin from 240mg to 200mg. He noted significant improvement in his pain, greater than 50% and he has been more physicaly active. His overall pain score has been averaging 5/10. The patient reported that the pain continued to be in the mid low back, predominantly to the left side. He would like to repeat the injections, periodically, given 2 months of pain relief and increased activity tolerance. The injection have helped him reduce the opiates as well. last lumbar trigger point injection was August 27, 2014. The patient did note some central low back pain. He was having some muscle spasms, but overall he was improved. upon examination, the patient did have palpable taut bands in the area of his pain. There was soft tissue dysfunction and spasm in the lumbar paraspinal region. The patient was diagnosed with sacroiliitis, postlaminectomy syndrome of lumbar region, lumbar disc degeneration, thoracic or lumbosacral neuritis, and fasciitis.

IMR ISSUES, DECISIONS AND RATIONALES

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

One trigger point injection to the lumbar spine with ultrasound guidance: Upheld

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: According to MTUS guidelines, trigger point injection is <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 syndrome, trigger point injections have not been proven effective. (Goldenberg, 2004) 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. There is no clear evidence of myofascial pain and trigger points over the lumbar and sciatic notch. There is no documentation of failure of oral medications or physical therapy in this case.

One prescription of Oxycontin 40mg, #120 with 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of opioids Page(s): 75-81.

Decision rationale: According to MTUS guidelines, Oxycodone as well as other short acting opioids are indicated for intermittent or breakthrough pain (page 75). It can be used in acute post operative pain. It is not recommended for chronic pain of longterm use as prescribed in this case.

In addition and according to MTUS guidelines, ongoing use of opioids should follow specific rules: (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 patient'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 patient'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 patients 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. There is justification for the use of Oxycontin at the same time. There is no documentation of functional and pain improvement with previous use of Oxycontin. There is no documentation of continuous compliance of patient to his medications. Therefore, the prescription of Oxycontin 40mg, #120 with 2 refills is not medically necessary.