MAXIMUS Federal Services

Case Number:	CM15-0027377		
Date Assigned:	02/19/2015	Date of Injury:	04/20/1998
Decision Date:	04/03/2015	UR Denial Date:	02/12/2015
Priority:	Standard	Application Received:	02/13/2015

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: Physical Medicine & Rehabilitation

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 56 year old male, who sustained an industrial injury on April 20, 1998. The injured worker suffered a traumatic brain injury and entire body damage due to oxygen deprivation related to a crush injury of the chest. Injuries included the head, neck thoracic spine, bilateral knees and right shoulder. The diagnoses have included chronic pain syndrome, cervical radiculopathy, cervicalgia, anoxic brain damage and cervical headaches. Treatment to date has included medications, diagnostic testing, cervical radio-frequency ablations, bilateral shoulder surgeries, right shoulder replacement in 2013, right shoulder tendon repair in 2013, right knee surgery tines three and left knee surgery times three. Current documentation notes that the injured worker complained of worsening neck pain. Physical examination revealed tenderness, decreased grip strength and a decreased range of motion. On February 12, 2015 Utilization Review modified a request for a Vicoprofen 7.5-200 mg # 150 and non-certified a request for a retrospective four trigger point injection on February 6, 2015 and a request for a four trigger point injection between February 6, 2015 and April 12, 2015. The MTUS, Chronic Pain Medical Treatment Guidelines, were cited. On February 13, 2015, the injured worker submitted an application for IMR for review of Vicoprofen 7.5-200 mg # 150, a retrospective four trigger point injection on February 6, 2015 and a four trigger point injection between February 6, 2015 and April 12, 2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Vicoprofen 7.5-200mg #150: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Weaning of medications.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria For Use Of Opioids;HydrocodoneAnti-inflammatories Page(s): 76-78, 88-89, 90, 22.

Decision rationale: The 56 year old patient presents with pain in neck, back and shoulders, rated 6-8/10 with medications and 10/10 without medications, as per progress report dated 11/18/14. The request is for VICOPROFEN 7.5 200 mg # 150. There is no RFA for this case, and the patient's date of injury 04/20/98. Medications, as per progress report dated 11/18/14, included Astepro, Axiron, Cialis, Clonazepam, Flomax, HCTZ, IBP, ProAir, and Vicoprofen. Diagnoses included spasm of muscle, cervical intervertebral disc displacement, bursitis and tendonitis of shoulder, and testicular hypofunction. In progress report dated 10/21/14, the patient complains of right hand, left leg, and sleep disturbances. The patient is status post right shoulder replacement surgery on 11/12/12, right shoulder surgery on 11/25/13, and multiple bilateral knee surgeries, as per progress report dated 09/12/14. The patient has returned to modified work, as per progress report dated 11/18/14.MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. MTUS p90 states, "Hydrocodone has a recommended maximum dose of 60mg/24hrs." Regarding NSAID's, MTUS page 22 state "Anti-inflammatories are the traditional first line of treatment, to reduce pain so activity and functional restoration can resume, but long-term use may not be warranted. A comprehensive review of clinical trials on the efficacy and safety of drugs for the treatment of low back pain concludes that available evidence supports the effectiveness of non-selective nonsteroidal anti-inflammatory drugs (NSAIDs) in chronic LBP and of antidepressants in chronic LBP." MTUS p60 also states, "A record of pain and function with the medication should be recorded," when medications are used for chronic pain. Vicoprofen contains Hydrocodone and Ibuprofen. The prescription for this medication was first noted in progress report dated 01/15/13, and the patient has been taking the medication consistently at least since then. In progress report dated 11/18/14, the treater states that the medication helps reduce pain from 101/10 to 6-8/10. The treater also states that medications provide functional improvement "by allowing him to get out of bed, dress with assistance, bathe with assistance, and manipulate objects such as dining utensils without undue pain." However, no UDS and CURES reports are available for review. Additionally, the treater uses general statements to indicate functional improvement but does not use a validated scale to demonstrate a measurable increase in function. There is no discussion about the side effects of the drug. MTUS requires a clear discussion regarding the 4As, including analgesia, ADLs, adverse side effects, and aberrant behavior, for continued opioid use. Hence, this request IS NOT medically necessary.

Retrospective 4 trigger point injection dos:02/06/2015: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of Trigger point injections.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines trigger point injections Page(s): 122.

Decision rationale: The 56 year old patient presents with pain in neck, back and shoulders, rated 6-8/10 with medications and 10/10 without medications, as per progress report dated 11/18/14. The request is for Retrospective 4 Trigger Point Injection DOS 02/06/15. There is no RFA for this case, and the patient's date of injury 04/10/98. Medications, as per progress report dated 11/18/14, included Astepro, Axiron, Cialis, Clonazepam, Flomax, HCTZ, IBP, ProAir, and Vicoprofen. Diagnoses included spasm of muscle, cervical intervertebral disc displacement, bursitis and tendonitis of shoulder, and testicular hypofunction. In progress report dated 10/21/14, the patient complains of right hand, left leg, and sleep disturbances. The patient is status post right shoulder replacement surgery on 11/12/12, right shoulder surgery on 11/25/13, and multiple bilateral knee surgeries, as per progress report dated 09/12/14. The patient has returned to modified work, as per progress report dated 11/18/14.The MTUS Guidelines, on page 122, state that '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." In this case, none of the progress reports discuss this request. This retrospective request is for an injection that was administered on 02/06/15.However, the most recent progress report available for review is dated 11/18/14. This report does not document the presence of trigger points during physical examination. Additionally, the treater states that medical management therapies such as medications are helping the patient with pain and function. Hence, the trigger point injection administered on 02/06/14 does not meet the criteria established by MTUS. This retrospective request IS NOT medically necessary.

4 Trigger point injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of Trigger point injections.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines trigger point injections Page(s): 122.

Decision rationale: The 56 year old patient presents with pain in neck, back and shoulders, rated 6-8/10 with medications and 10/10 without medications, as per progress report dated 11/18/14. The request is for 4 Trigger Point Injection. There is no RFA for this case, and the patient's date of injury 04/10/98. Medications, as per progress report dated 11/18/14, included Astepro, Axiron, Cialis, Clonazepam, Flomax, HCTZ, IBP, ProAir, and Vicoprofen. Diagnoses included spasm of muscle, cervical intervertebral disc displacement, bursitis and tendonitis of shoulder, and testicular hypofunction. In progress report dated 10/21/14, the patient complains of right hand, left leg, and sleep disturbances. The patient is status post right shoulder replacement surgery on 11/12/12, right shoulder surgery on 11/25/13, and multiple bilateral knee surgeries, as per progress report dated 09/12/14. The patient has returned to modified work, as per progress report dated 11/18/14.The MTUS Guidelines, on page 122, state that "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 circumscribedtrigger 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."In this case, the patient has received trigger point injections on 02/06/15. However, the impact of this procedure on pain and function is not known. MTUS allows repeat injections only with greater than 50% pain relief over a period of six weeks along with documented evidence of functional improvement. Additionally, the frequency should not be at an interval less than two months. The reports lack documentation required to make a determination based on MTUS. Hence, the request IS NOT medically necessary.