

Case Number:	CM15-0075886		
Date Assigned:	04/27/2015	Date of Injury:	02/28/2002
Decision Date:	06/15/2015	UR Denial Date:	04/08/2015
Priority:	Standard	Application Received:	04/21/2015

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:

This 46-year-old female sustained an industrial injury to the neck on 2/26/02. Previous treatment included x-rays, computed tomography, magnetic resonance imaging, trigger point injections, chiropractic therapy and medications. In a PR-2 dated 2/17/15, the injured worker complained of neck pain rated 9/10 on the visual analog scale with radiation to bilateral upper extremity, neck and head. The injured worker reported daily headaches with visual disturbances and a feeling of pressure points along the cranium. Current diagnoses included cervical disc displacement without myelopathy, bicipital tenosynovitis, cervical spine spondylosis without myelopathy, closed dislocation of the shoulder, complete rupture of rotator cuff, ulnar nerve lesion, migraines and myalgia. The treatment plan included a urine drug screen, trigger point injections to bilateral trapezius and cervical spine paraspinal musculature, bilateral epicondyle tendon sheath injections and medications (Norco, Naprelan, Neurontin, Duragesic patch and Ambien).

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Norco, Opioids, specific drug list.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for the Treatment of Chronic Pain Page(s): 91-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: According to the CA MTUS and ODG, Norco 10/325mg (Hydrocodone/Acetaminophen) is a short-acting opioid analgesic indicated for moderate to moderately severe pain, and is used to manage both acute and chronic pain. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is no documentation of the medication's functional benefit. Medical necessity of the requested item has not been established. Of note, discontinuation of an opioid analgesic should include a taper, to avoid withdrawal symptoms. The requested medication is not medically necessary.

Ambien 10mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Zolpidem (Ambien).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Insomnia treatment.

Decision rationale: Ambien (Zolpidem) is a prescription short-acting non-benzodiazepine hypnotic, which is recommended for short-term treatment of insomnia (two to six weeks). Ambien is indicated for treatment of insomnia with difficulty of sleep onset and/or sleep maintenance. Longer-term studies have found Ambien to be effective for up to 24 weeks in adults. It can be habit-forming, and may impair function and memory more than opioid analgesics. There is also concern that Ambien may increase pain and depression over the long-term. The treatment of insomnia should be based on the etiology, and pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. In this case, Ambien has been used since 2/17/15 (for approximately 6 weeks). There is no documentation indicating the medical necessity for continued medical therapy with this medication. The requested medication is not medically necessary.

Trigger Point Injections to the Bilateral Trapezi and Paracervical Musculature: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Elbow (Acute and Chronic), Trigger Point Injections.

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

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. In this case, the patient underwent previous trigger point injections to the bilateral splenius capitis, bilateral splenius cervicis, and bilateral trapezius musculature on 8/11/14. Documentation from the physical exam of 9/11/14 indicates the patient continued to rate the pain 8/10, and there were still objective findings of palpable myofascial bands to the bilateral splenius capitis and bilateral trapezius with referred pain. Based on the patient's poor response to previous trigger point injections and the lack of a twitch response, repeat injections are not indicated. Medical necessity for the requested injections has not been established. The requested trigger point injections are not medically necessary.

Bilateral Epicondyle Tendon Sheath Injections: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Elbow (Acute and Chronic), Trigger Point Injections.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Corticosteroid injections to the elbow.

Decision rationale: According to the ODG, steroid injections are not recommended as a routine intervention for epicondylitis, based on recent research. In the past, a single injection was suggested as a possibility for short-term pain relief in cases of severe pain from epicondylitis, but beneficial effects persist only for a short time, and the long-term outcome could be poor. The significant short-term benefits of corticosteroid injection are paradoxically reversed after six weeks, with high recurrence rates, implying that this treatment should be used with caution in the management of tennis elbow. While there is some benefit in short-term relief of pain, patients requiring multiple corticosteroid injections to alleviate pain have a guarded prognosis for continued nonoperative management. Corticosteroid injection does not provide any long-term clinically significant improvement in the outcome of epicondylitis, and rehabilitation should be the first line of treatment in acute cases, but injections combined with work modification may have benefit. In this case, there is no documentation of clinical findings consistent with epicondylitis. Medical necessity for the requested treatment has not been established. The requested treatment is not medically necessary.