

Case Number:	CM15-0099844		
Date Assigned:	06/02/2015	Date of Injury:	04/06/2004
Decision Date:	07/07/2015	UR Denial Date:	04/29/2015
Priority:	Standard	Application Received:	05/26/2015

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, Tennessee
 Certification(s)/Specialty: Emergency 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 43-year-old male, who sustained an industrial injury on April 6, 2004. The injured worker's initial complaints and diagnoses are not included in the provided documentation. The injured worker was diagnosed as having cervical disc disease, lumbar disc disease, cervicgia/neck pain, lumbago, facet syndrome, and headache - not otherwise specified. Diagnostic studies to date have included MRIs, x-rays, and urine drug screening. The most recent urine drug screen performed on January 6, 2015, was positive for Hydrocodone, Norhydrocodone, and Acetaminophen. Treatment to date has included cervical facet joint injections, cervical medial branch blocks, and medications including pain, muscle relaxant, anti-epilepsy, antidepressant, anti-anxiety, and topical non-steroidal anti-inflammatory. On April 2, 2015, the injured worker complains of ongoing cervical spine, low back, and right lower extremity pain. His severe left neck pain and headaches are decreased by 75% following the radiofrequency neurotomy of the left cervical 4-5 and cervical 5-6 medial branch nerves performed on February 18, 2015. He complains of upper trapezius muscle tightness and tenderness with aching pain and stiffness. His medications remain helpful and improve his functional status by assisting him in his activities of daily living, mobility, and restorative sleep. The physical exam revealed tenderness of the of the bilateral paracervical muscles, right greater than left cervical facet tenderness, decreased cervical range of motion with pain, normal cervical and bilateral upper extremity motor strength and reflexes, and decreased sensation of the right middle finger (cervical 7) and right fourth finger, fifth finger, ulnar hand, and distal forearm (cervical 8). There was a normal gait, and transverse process tenderness at the right lumbar 4 and the bilateral lumbar 4 paraspinal region, and normal lumbar range of motion with pain, and normal motor strength, sensation, and reflexes of the bilateral lower extremities. The treatment plan includes trigger point injections and Norco.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective 1 Trigger Point Injections (DOS: 4/2/2015): 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 Pain Interventions and Guidelines Page(s): 122.

Decision rationale: Trigger point injections are recommended only for myofascial pain syndrome as indicated below, with limited lasting value. 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. Criteria for use of trigger point injections are as follows: (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 documentation in the medical record does not support that trigger points are present. Trigger point injections are not medically necessary. The request should not be authorized.

60 Norco 5/325mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 11, 74-96.

Decision rationale: Norco is the compounded medication containing hydrocodone and acetaminophen. Chronic Pain Medical Treatment Guidelines state that opioids are not recommended as a first line therapy. Opioid should be part of a treatment plan specific for the patient and should follow criteria for use. Criteria for use include establishment of a treatment plan, determination if pain is nociceptive or neuropathic, failure of pain relief with non-opioid analgesics, setting of specific functional goals, and opioid contract with agreement for random drug testing. If analgesia is not obtained, opioids should be discontinued. The patient should be screened for likelihood that he or she could be weaned from the opioids if there is no

improvement in pain or function. It is recommended for short-term use if first-line options, such as acetaminophen or NSAIDs have failed. Opioids may be a safer choice for patients with cardiac and renal disease than antidepressants or anticonvulsants. Acetaminophen is recommended for treatment of chronic pain & acute exacerbations of chronic pain. Acetaminophen overdose is a well-known cause of acute liver failure. Hepatotoxicity from therapeutic doses is unusual. Renal insufficiency occurs in 1 to 2% of patients with overdose. The recommended dose for mild to moderate pain is 650 to 1000 mg orally every 4 hours with a maximum of 4 g/day. In this case the patient has been receiving Norco since at least February 2013 and has not obtained analgesia. Criteria for long-term opioid use have not been met. The request should not be authorized.