

Case Number:	CM15-0171399		
Date Assigned:	09/11/2015	Date of Injury:	01/28/2013
Decision Date:	10/09/2015	UR Denial Date:	08/06/2015
Priority:	Standard	Application Received:	08/31/2015

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: North Carolina

Certification(s)/Specialty: Family Practice

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 28 year old male who sustained an industrial injury on 01-28-2013. Records show that the injured worker was being treated for cervical pain, shoulder pain, thoracic pain and headaches. Treatment to date has included physical therapy, medication, previous injections (2 in the left scapula area) and chiropractic treatment. Documentation shows medications tried and failed included Advil, Aleve, Aspirin, Bengay, Flexeril and Norco. MRI of the cervical spine in 2014 was normal. MRI of the thoracic spine was normal. According to a chiropractic progress report dated 05-06-2015, moderate and worsening bilateral thoracic trigger points were noted. The treatment plan included trigger point injections every 3 months. According to an office visit report dated 07-29-2015, the injured worker was seen for his ongoing left shoulder worker's comp injury. Current pain was rated 3 on a scale of 1-10 described as aching. He was currently undergoing chiropractic treatment "which was helping". The goal was to decrease narcotic usage by 70-80% and increase quality of life. Objective findings included tenderness to palpation of the left shoulder. Range of motion was decreased due to pain, especially abduction and external rotation. Pinprick revealed no dermatome hypalgesia on the left. Muscle tone did not reveal any asymmetries of bulk tone. Muscle strength of deltoids, biceps, brachioradialis, triceps, wrist extensors, wrist flexors, dorsal interossei, palmer interossei, left opponens pollicis and hand grips were 5 out of 5 on the right and 4 out of 5 on the left. Biceps reflexes, triceps reflexes and brachioradialis reflexes were 2 out of 4 on the right and left. There was no Hoffman's sign noted. Superficial reflexes were normal. The treatment plan included Medrox ointment x 2. Trigger point injections x 2 subscapular were

recommended. An authorization request dated 08-03-2015 was submitted for review. The requested services included Medrox ointment x 2, trigger point injections x 3 and follow up appointment. On 08-06-2015, Utilization Review non-certified the request for Medrox ointment #2 and three trigger point injections.

IMR ISSUES, DECISIONS AND RATIONALES

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

Medrox ointment #2: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: The California chronic pain medical treatment guidelines section on topical analgesics states: Recommended as an option as indicated below. Largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. (Namaka, 2004) These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. (Colombo, 2006) Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor). (Argoff, 2006) There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The requested medication contains ingredients, which are not indicated per the California MTUS for topical analgesic use. Therefore, the request is not medically necessary.

Three (3) trigger point injections: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Trigger point injections.

Decision rationale: The California chronic pain medical treatment guidelines section on trigger point injections states: Trigger point injections: 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) 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. (Colorado, 2002) (BlueCross BlueShield, 2004) The provided clinical documentation fails to show circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain. Therefore, criteria have not been met and the request is not medically necessary.