MAXIMUS Federal Services

Case Number:	CM15-0071895		
Date Assigned:	04/22/2015	Date of Injury:	01/23/2003
Decision Date:	05/20/2015	UR Denial Date:	04/10/2015
Priority:	Standard	Application Received:	04/15/2015

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: 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 67-year-old male, who sustained an industrial injury on 01/23/2003. He has reported subsequent back pain and was diagnosed with low back pain and lumbar facet arthropathy. Treatment to date has included oral and topical pain medication, home exercise program and radiofrequency lessoning. In a progress note dated 03/31/2015, the injured worker complained of low back pain radiation to the lower extremity. Objective findings were notable for exquisite point tenderness over the right quadrates lumborum at L3. A request for authorization of a trigger point injection and Baclofen/Bupivacaine/Cyclobenzaprine/ Gabapentin/Orphenadrine/Pentoxifyline cream was made.

IMR ISSUES, DECISIONS AND RATIONALES

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

Trigger point injection, provided on March 31, 2015: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 122.

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

Decision rationale: The requested Trigger point injection, provided on March 31, 2015, is not medically necessary. Chronic Pain Medical Treatment Guidelines, Trigger Point Injections, Page 122, note 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. The injured worker has flow back pain radiation to the lower extremity. Objective findings were notable for exquisite point tenderness over the right quadrates lumborum at L3. The treating physician has not documented a twitch response on physical exam. The criteria noted above not having been met, Trigger point injection, provided on March 31, 2015 is not medically necessary.

Compound cream (baclofen 2%/bupivacaine 1%/cyclobenzaprine 2%/gabapentin 6%/orphenadrine 5%/pentoxifyline 3%), 120 grams: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111 - 113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines page 111-113, Topical Analgesics Page(s): 111-113.

Decision rationale: The requested Compound cream (baclofen 2%/bupivacaine 1%/ cyclobenzaprine 2%/gabapentin 6%/orphenadrine 5%/pentoxifyline 3%), 120 grams, is not medically necessary. California Medical Treatment Utilization Schedule (MTUS), 2009, Chronic pain, page 111-113, Topical Analgesics, do not recommend topical analgesic creams as they are considered "highly experimental without proven efficacy and only recommended for the treatment of neuropathic pain after failed first-line therapy of antidepressants and anti-convulsants". The injured worker has flow back pain radiation to the lower extremity. Objective findings were notable for exquisite point tenderness over the right quadrates lumborum at L3. The treating physician has not documented trials of anti-depressants or anti-convulsants. The treating physician has not documented intolerance to similar medications taken on an oral basis, nor objective evidence of functional improvement from any previous use. The criteria noted above not having been met, Compound cream (baclofen 2%/bupivacaine 1%/ cyclobenzaprine 2%/gabapentin 6%/orphenadrine 5%/pentoxifyline 3%), and 120 grams is not medically necessary.