

Case Number:	CM13-0026875		
Date Assigned:	09/08/2014	Date of Injury:	09/25/2006
Decision Date:	10/09/2014	UR Denial Date:	09/06/2013
Priority:	Standard	Application Received:	09/20/2013

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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation, and is licensed to practice in Texas & Ohio. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 46-year-old male who reported an injury on 09/25/2006. The injured worker stated that on the date of his injury, he was assaulted after he checked a room that he had just vacated as it was his customary duties. The injured worker sustained injuries to his right knee, upper back, lower back, and right shoulder. The injured worker's prior treatment history included physical therapy, x-rays, MRI studies of the head, injections, and 4 epidural injections to his lumbar spine. The last injections were administered in approximately 07/2011. On 06/05/2013, the injured worker had an MRI that revealed no findings consistent with radiculopathy and was negative for nerve root encroachment. The injured worker stated the injections improved his upper and lower back pain; however, they have not resolved his pain. Additionally, the injured worker reported having been treated for epidural injections in his right shoulder and right knee, also with minor benefit. The injured worker was evaluated on 08/13/2013 and it was documented that the injured worker complained of pain that was 8.5/10. The injured worker reported worsening by 20%. The physical examination appeared to indicate there was tenderness, decreased range of motion, and the remainder was illegible as it was handwritten. The injured worker was evaluated on 09/10/2013 and it was documented that the injured worker complained of mid back and lower back pain rated at 8/10. The range of motion of the lumbar spine was flexion was 20 degrees, extension was 10 degrees, right/left bending was 10 degrees, and right/left rotation was 25 degrees. Medications included Naprosyn and tramadol. Diagnoses included right posterior shoulder strain with myofascial tenderness, musculoligamentous tenderness to the cervical spine consistent with musculoligamentous injury with a history of disc protrusions and left occipital neuritis, subacromial bursitis, right shoulder with impingement, rule out internal derangement of the right knee, musculoligamentous tenderness to the lumbar spine consistent with musculoligamentous injury and superimposed disc

protrusion associated with lumbar radiculitis. The Request for Authorization was not submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

LS ESI injections x3 under fluoroscopic guidance L5-S1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs) Page(s): 46.

Decision rationale: The California Treatment Guidelines recommend epidural steroid injections as an option for treatment of radicular pain (defined as pain in dermatome distribution with corroborative findings of radiculopathy). Epidural steroid injection can offer short-term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electro diagnostic testing. Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). Additionally, failure to respond to conservative treatment is also a criterion for ESIs. There was lack of documentation of home exercise regimen and pain medication management or the outcome measurements for the injured worker. Additionally, the provider indicated the injured worker receiving epidural steroid injection however, the stated the injections gave him minor benefit. As such, the request for LS ESI Injections X 3 under fluoroscopic guidance at L5-S1 is not medically necessary.

Lumbar Spine Trigger Point Injections: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger Point Injections & Criteria for the use of Trigger point Injections Page(s): 122.

Decision rationale: California (MTUS) Chronic Pain Medical Guidelines recommends trigger point injections 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 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) for fibromyalgia syndrome, trigger point injections have not been proven effective. The guidelines also states trigger point injections may be used 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 guidelines only recommend the use of trigger pint injections for myofascial pain syndrome and not radiculopathy. The provider indicated the injured worker stated he has had epidural injections in the past injections in the past however, the long-term outcome measurements or functional improvement goals were not provided. Given the above, the request for lumbar spine trigger point injections are not medically necessary.

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