

Case Number:	CM13-0043110		
Date Assigned:	12/27/2013	Date of Injury:	12/24/2007
Decision Date:	02/27/2014	UR Denial Date:	10/09/2013
Priority:	Standard	Application Received:	10/21/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Pain Management has a subspecialty in Disability Evaluation and is licensed to practice in California, DC, Maryland, and Florida. 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 physician 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:

Patient is a 63 year old male with stated date of injury of 09/06/2006. Mechanism of injury: Symptoms was a result of cumulative trauma while working as a truck driver. According to Medical Report on 9/11/13 by [REDACTED], the patient continued to complain of lower back pain but improved since the last visit. The patient had trigger point injections to lower back which patient was able to sleep better at night with improved mobility. On exam of lumbar spine, tenderness was noted bilaterally with increased muscle rigidity. There were numerous trigger points palpable and tender throughout the lumbar paraspinal muscles. Muscle guarding was noted with range of motion (ROM). Wartenberg pinprick was decreased in the posterolateral thigh and postolateral calf more so on the right when compared to the left. There was mild decrease dorsiflexion of the right foot and ankle. The straight leg raise In the modified sitting position was positive at 65 degrees on the right Range of motion of the lumbar spine: Flexion was 45 degrees, extension 15 degrees, left lateral bend was 20 degrees and right lateral bend was 20 degrees. The patient was diagnosed with 1. Lumbar spine sprain/strain syndrome. 2. Right lower extremity radiculitis. 3. Right Achilles tendon partial tear 4. Bilateral shoulder impingement syndrome, right greater than left. 5. Cervical sprain/strain syndrome. 6. Reactionary depression/anxiety The patient's height was 5 feet 10 inches and weighed approximately 200 pounds, per 8/25/10 report. Current medications: According to Medical Report on 9/11/13 by [REDACTED], Norco 10/325 mg b.i.d, pm; Anaprox DS 550 mg, b.i.d. prn; Prilosec 20 mg, b.i.d.; Fexmid 7.5 mg b.i.d. Surgeries: The patient had two right arthroscopic shoulder surgeries in 2008 and 2/1/2010. In addition, the patient recently had a right Achilles tendon repair in 2008. According to Medical Report on 9/11/13 by [REDACTED], the patient the had following: Electromyography Nerve conduction Velocity study

(EMG/NCV) of the bilateral upper extremities performed on 2/1/2008 by [REDACTED] documented a mild bilateral carpal tunnel syndrome. A lumbar spine Magnetic Resonance Imaging (MRI) performed at True MRI on 1/24/2008 interpreted by [REDACTED] and documented 2-mm disc bulges at L3-4 and L4-5. A cervical spine MRI performed at [REDACTED] on 1/24/2008, interpreted by [REDACTED] documented disc desiccation at C2-3, C3-4, C4-5 and C5-6 with straightening of the cervical spine probably due to mild spasm. There were 2- to 3-mm disc bulges at C4-5, C5-6, C6-7, and C7-T1 most significant at C5-6 with bilateral neural foramina narrowing and hypertrophy. A left shoulder MRI performed at [REDACTED] on 1/24/2008, interpreted by [REDACTED] and documented acromioclavicular joint osteoarthritis, which may cause potential impingement with supraspinatus. There was an articular surface partial thickness tear of the tendon in the infraspinatus. (There was no objective interpretation of the results attached in the medical report submitted). The patient received 4 trigger point injections today and reported good pain relief of greater than 50 percent and an increased ROM a few minutes later. The patient received trigger point injections to lower back (Undated) which provided at least 60 percent relief lasting a good three weeks. But pain returned. ❌

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro 4 Trigger Point Injections, Lumbar: 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 Injection Page(s): 122.

Decision rationale: The history and documentation do not objectively support the request for 4 trigger point injections to the lumbar spine for the patient chronic condition. She had spasms which is also suggested by the MRI scan of but no trigger points are identified with referred pain or a twitch response. It is not clear whether myofascial pain syndrome has been diagnosed and the medical necessity of this request has not been clearly demonstrated. The guideline stated that 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; Therefore the request for RETRO 4 TRIGGER POINT INJECTIONS, LUMBAR is not medically necessary. According to MTUS Chronic Pain Medical Treatment Guidelines Trigger Point Injection is recommended only for myofascial pain syndrome with limited lasting value. Not recommended for radicular pain. 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. There is a lack of evidence from published clinical trials documenting the frequency and number of trigger point injections. The ASIPP consensus-based guidelines for pain management advocate as many as eight trigger point injections per body area per year; however, this number is not supported by clinical trial data. [1] Therefore, conclusions cannot be made concerning the effectiveness of more than four trigger point injections per year per body area. Three Cochrane systematic reviews of published literature concluded that there is a lack of evidence from high quality studies for trigger point injection therapy for low back[3] or neck[4] pain, or for dry needling [5] for low back pain