

<b>Case Number:</b>	CM14-0116245		
<b>Date Assigned:</b>	08/04/2014	<b>Date of Injury:</b>	06/18/2008
<b>Decision Date:</b>	12/31/2014	<b>UR Denial Date:</b>	07/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/24/2014

### 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 Preventive Medicine, and is licensed to practice in California. 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:

According to the records made available for review, this is a 36-year-old male with a 6/18/08 date of injury. At the time (7/18/14) of request for authorization for Bilateral L4-L5 and L5-S1 Transforaminal Epidural Steroid Injections under fluoroscopy and Myofascial trigger point injections X 4, there is documentation of subjective (low back pain radiating into the bilateral buttocks and posterolateral legs from the hips to the heels and over the lateral feet) and objective (decreased lumbar range of motion, tenderness to palpation over the lumbosacral paraspinal musculature, tenderness to palpation over the bilateral quadratus lumborum and erector spinae muscles with spasms, trigger points, and twitching of the muscle bellies; tenderness to palpation over the sacroiliac joints with myofascial trigger points; tenderness to palpation over the ischiogluteal tuberosities and greater trochanteric bursae, and dysesthesia over the lateral calves and feet) findings, current diagnoses (degeneration of lumbar intervertebral disc, spasm of piriformis muscles, lumbosacral radiculitis, sciatica, lumbago, lumbosacral spondylosis, lumbar facet joint pain, myofascial pain, and bursitis of hip), and treatment to date (lumbar epidural steroid injection at L3-4 and L4-5 over 18 months ago with over 90% pain relief for 6 months; physical therapy, medications, and activity modification). Regarding Bilateral L4-L5 and L5-S1 Transforaminal Epidural Steroid Injections under fluoroscopy, there is no documentation of decreased need for pain medications and functional response following previous injection. Regarding Myofascial trigger point injections X 4, there is no documentation of radiculopathy is not present (by exam).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Bilateral L4-L5 and L5-S1 Transforaminal Epidural Steroid Injections under fluoroscopy:**  
Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Epidural Steroid Injections (ESIs)

**Decision rationale:** MTUS reference to ACOEM guidelines identifies documentations of objective radiculopathy in an effort to avoid surgery as criteria necessary to support the medical necessity of epidural steroid injections. ODG identifies documentation of at least 50-70% pain relief for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year, as well as decreased need for pain medications, and functional response as criteria necessary to support the medical necessity of additional epidural steroid injections. Within the medical information available for review, there is documentation of diagnoses of degeneration of lumbar intervertebral disc, spasm of piriformis muscles, lumbosacral radiculitis, sciatica, lumbago, lumbosacral spondylosis, lumbar facet joint pain, myofascial pain, and bursitis of hip. In addition, there is documentation of a previous lumbar epidural steroid injection at L3-4 and L4-5 over 18 months ago with over 90% pain relief for 6 months. However, there is no documentation of decreased need for pain medications and functional response following previous injection. Therefore, based on guidelines and a review of the evidence, the request for Bilateral L4-L5 and L5-S1 Transforaminal Epidural Steroid Injections under fluoroscopy is not medically necessary.

**Myofascial trigger point injections X 4:** 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 Trigger point injections Page(s): 122.

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of myofascial pain syndrome; circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain; symptoms have persisted for more than three months; medical management therapies such as ongoing stretching exercises, physical therapy, NSAIDs and muscle relaxants have failed to control pain; radiculopathy is not present (by exam, imaging, or neuro-testing); and no more than 3-4 injections per session, as criteria necessary to support the medical necessity of trigger point injections. Within the medical information available for review, there is documentation of diagnoses of degeneration of lumbar intervertebral disc, spasm of piriformis muscles, lumbosacral radiculitis, sciatica, lumbago, lumbosacral spondylosis, lumbar facet joint pain, myofascial pain, and bursitis of hip. In addition, there is documentation of myofascial pain syndrome. In addition, given documentation

of objective findings (tenderness to palpation over the bilateral quadratus lumborum and erector spinae muscles with spasms, trigger points, and twitching of the muscle bellies; and tenderness to palpation over the sacroiliac joints with myofascial trigger points), there is documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain. Furthermore, there is documentation that symptoms have persisted for more than three months; medical management therapies such as ongoing stretching exercises, physical therapy, and medications have failed to control pain; and no more than 3-4 injections per session. However, given documentation of objective findings (dysesthesia over the lateral calves and feet), there is no documentation of radiculopathy is not present (by exam). Therefore, based on guidelines and a review of the evidence, the request for Myofascial trigger point injections X 4 is not medically necessary.