

Case Number:	CM14-0172600		
Date Assigned:	10/23/2014	Date of Injury:	03/13/2006
Decision Date:	12/17/2014	UR Denial Date:	09/25/2014
Priority:	Standard	Application Received:	10/20/2014

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 Neurology, has a subspecialty in Neuromuscular Medicine and is licensed to practice in New Jersey. 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 patient is a 49-year-old man who sustained a work related injury on March 13, 2006. Subsequently, he developed chronic low back pain. The patient underwent a back surgery on January 6, 2010, with little improvement for his pain. MRI of the lumbar spine dated October 15, 2013 showed postsurgical changes made with posterior lumbar interbody fusion at L4-5 and L5-S1 levels, both of which are solid. However, the adjacent level above the fusions at L3-4 shows disc desiccation with mild loss of disc height. There is thickening of the ligamentum flavum. There is a 5 mm broad-based posterior disc protrusion with associated annular fissuring that indents the thecal sac and encroaches on both central L4 nerve roots in the lateral recesses causing moderate to severe spinal canal stenosis. There is also moderate to severe narrowing of the right lateral recess and moderate narrowing of the left lateral recess. CT Myelogram of the lumbar spine dated October 14, 2014 showed postsurgical changes from a solid posterior lumbar interbody fusion and decompression at the L4-5 and L5-S1 levels. The adjacent level showed degeneration at the level above the fusions at L3-4 where there is moderate spinal canal stenosis, moderate to severe narrowing of the right lateral recess, and moderate narrowing of the left lateral recess stenosis at the L2-3 level where there is a 3 mm broad-based central protrusion which has developed since the last MRI of 2013. According to a progress report dated October 20, 2014, the patient continued to rate his low back pain at 9/10 without medications and 6-7/10 with medications. He stated that the last Toradol injection helped. Physical examination revealed moderately severe paraspinal muscle spasm, severe lumbar region muscle spasm, and fibro muscular nodules. The range of motion was limited by pain. Kemp's test was positive on the left side. Facet loading was positive bilaterally. Testing for light touch, sharp and dull pain, and vibration were normal. The patient was diagnosed with L3-4 herniated disc, L3-4 annular disc

tear, left L4, L5, S1 radiculopathy, moderate lumbar muscle spasm, and chronic low back pain. The provider requested authorization for Kenalog injection and Marcaine injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Kenalog injection 40mg for the lower back: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger Point Injections; Criteria for the use of Trigger Point In. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic Pain, Steroid Injections

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger point injections Page(s): 122. Decision based on Non-MTUS Citation (Ud-Din, Bowring et al. 2013)

Decision rationale: According to MTUS guidelines, trigger point injection is 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) 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 no clear evidence of myofascial pain and trigger points over the lumbar and sciatic notch. There is no documentation of failure of oral medications or physical therapy in this case. Therefore, the request for Kenalog injection 40mg for the lower back is not medically necessary.

Marcaine injection 0.75% for the lower back: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger Point Injections; Criteria for the use of Trigger Point In. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic Pain, Steroid Injections

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

Decision rationale: According to MTUS guidelines, trigger point injection is 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) 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 no clear evidence of myofascial pain and trigger points over the lumbar and sciatic notch. There is no documentation of failure of oral medications or physical therapy in this case. Therefore, the request for Marcaine injection 0.75% for the lower back is not medically necessary.