

<b>Case Number:</b>	CM14-0045240		
<b>Date Assigned:</b>	07/02/2014	<b>Date of Injury:</b>	09/07/2007
<b>Decision Date:</b>	08/20/2014	<b>UR Denial Date:</b>	03/20/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/14/2014

### 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 Physical Medicine and Rehabilitation 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:

The injured worker is a 44-year-old female who reported an injury on 09/07/2007. The mechanism of injury was not provided within the documentation. The injured worker underwent hardware removal/revision decompression fusion 09/03/2013. The injured worker's initial transforaminal lumbar interbody fusion was done on 8/22/2009 for L4-S1. The injured worker presented for a clinical re-evaluation for a flare-up of pain in her low back rated at 4/10 with spasm. The physical examination noted tenderness to palpation throughout the midline lumbar spine and paraspinal area on the right. Lumbar flexion was 60 degrees, extension 20 degrees, and side-bending rotation was 30 degrees. She had 5/5 strength in her legs. Sensation was intact throughout bilateral lower extremities. She had a negative Babinski, negative straight leg raise in bilateral legs. No clonus bilaterally. Reflexes were 2+ bilaterally and symmetric. The injured worker had a computed tomography (CT) scan done on this lumbar fusion. There was a magnetic resonance imaging (MRI) on 04/11/2011, showing scar tissue at the right L5-S1 area and minimal bulge at L3-4. An x-ray showed stable L4-S1 transforaminal lumbar interbody fusion. The injured worker's diagnoses were noted to be lumbar spondylolisthesis, status post L4-S1 transforaminal lumbar interbody fusion, recent hardware removal surgery and augmentation of fusion surgery, and lumbar spine hardware removal surgery. The treatment plan was for additional lumbar spine physiotherapy and to continue medications. In addition, a trigger point injection/facet block for flare-ups of pain, inflammation, and spasm. The injured worker's past treatments were noted to be physical therapy, medications, and surgical intervention. The provider's rationale for the request was provided within the documentation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Trigger point injection for the lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 11th edition (web) 2013, Low Back, Trigger Point Injections (TPIs).

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

**Decision rationale:** The request for trigger point injections for the lumbar spine is not medically necessary. The California MTUS Chronic Pain Medical Treatment Guidelines recommend trigger point injections only for myofascial pain syndrome. Trigger point injections with anesthetics such as bupivacaine are recommended for non-resolving trigger points, but the addition of a corticosteroid is not generally recommended. Trigger point injections are 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. 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. The guidelines provide criteria for the use of trigger point injections: Documentation of a circumscribed trigger point with evidence upon palpation of a twitch response as well as referred pain must be noted. Symptoms must have persisted and be documented for more than 3 months. Failure to control pain with medical management therapies such as ongoing stretching exercises, physical therapy, NSAIDS and muscle relaxants must be documented within the examination period. Trigger point injections with any substance other than local anesthetic with or without steroid are not recommended. The documentation provided for review fails to meet the criteria for the use of trigger point injections. Documentation failed to indicate a palpable twitch, failure of conservative care, and persistent symptoms of greater than 3 months. In addition, the provider's request fails to indicate what level of the lumbar spine the trigger point injection will be administered, as well as the anesthetic to be used. Therefore, the request for trigger point injection for the lumbar spine is not medically necessary.