

<b>Case Number:</b>	CM14-0070346		
<b>Date Assigned:</b>	07/14/2014	<b>Date of Injury:</b>	03/16/2007
<b>Decision Date:</b>	09/17/2014	<b>UR Denial Date:</b>	05/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/15/2014

### 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 Family 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:

This is a 72 year old male patient who reported an industrial injury to the back on 3/16/2007 attributed to performing his customary job tasks reported as falling and striking his shoulder against concrete. The patient was assessed as maximum medical improvement (MMI) on 11/19/2009. The patient was diagnosed with rotator cuff tear, sprain strain of the cervical thoracic and lumbar spine, musculoligamentous strain with lumbar spondylosis, bilateral knee sprain, and right ankle sprain. The patient was noted be status post rotator cuff repair with SA D and distal clavicle excision of the right shoulder. The patient was noted to have a recurrent tear present with a reported subluxation of the shoulder joint. The objective findings on examination included tenderness over the thoracic spine and teres minor bilaterally; weakness of the supraspinatus on the right. The patient was provided to trigger point injections to the paraspinous lumbar spine.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective 2 trigger point injections to the lumbar paraspinal muscles, dates of service 3/19/2014 to 3/19/2014:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines TRIGGER POINT INJECTIONS Page(s): 122-123. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter-trigger point injections.

**Decision rationale:** The objective findings documented did not meet the criteria recommended by the CA MTUS and the ACOEM Guidelines for the use of TPIs for chronic back pain. There is no demonstrated medical necessity for prn trigger point injections to the objective findings that included spasm and TTP documented on examination. The medical records submitted for review, fail to document any red flags or significant functional objective deficits that would preclude the patient from being able to participate in an independent home exercise program. The patient should be placed on active participation in an independent applied home exercise program consisting of stretching, strengthening and range of motion exercises. The use of trigger point injections are recommended for the treatment of chronic back pain in certain conditions when trigger points are identified with a myofascial pain syndrome as a secondary or tertiary treatment in conjunction with an active defined program for rehabilitation when the patient is demonstrated not to be improving with conservative treatment. The CA MTUS and the Official Disability Guidelines state that "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." The CA MTUS and the Official Disability Guidelines recommend the use of trigger point injections for "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 with reduced medication use 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; (9) There should be evidence of continued ongoing conservative treatment including home exercise and stretching. Use as a sole treatment is not recommended; (10) If pain persists after 2 to 3 injections the treatment plan should be reexamined as this may indicate an incorrect diagnosis, a lack of success with this procedure, or a lack of incorporation of other more conservative treatment modalities for myofascial pain. It should be remembered that trigger point injections are considered an adjunct, not a primary treatment." The CA MTUS and the Official Disability Guidelines do not recommend the use of trigger point injections in the absence of myofascial pain syndromes, without documentation of circumscribed trigger points, or without an ongoing active rehabilitation program. There is no provided documentation consistent with myofascial pain or documented trigger points with muscle fasciculations in the clinical narrative. The patient's documented diagnoses do not include myofascial pain syndrome and there are no defined specific trigger points and other conservative treatment has not been attempted. There

was no demonstrated medical necessity for the two (2) administered trigger point injections on 3/19/2014.