

<b>Case Number:</b>	CM14-0087102		
<b>Date Assigned:</b>	07/23/2014	<b>Date of Injury:</b>	12/09/2012
<b>Decision Date:</b>	10/08/2014	<b>UR Denial Date:</b>	05/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/10/2014

### 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 Internal Medicine, has a subspecialty in Pulmonary Diseases 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 45-year-old female who reported injury on 12/09/2012, reportedly while she was pulling pallets of merchandise out onto the store floor utilizing a pallet jack and she experienced the onset of stabbing pain in her low back. The injured worker's treatment history included x-rays, MRI studies, physical therapy, chiropractic sessions and cortisone injections. The injured worker had a transforaminal epidural steroid injection on the left L5 and trigger point injections at bilateral lumbar paraspinal muscles times 3 dated 01/16/2014. The injured worker had undergone an EMG/NCS of upper extremities on 01/27/2014, that revealed mild median sensory demyelinating neuropathy across the wrist with mild right carpal tunnel syndrome, mild left ulnar sensory demyelinating neuropathy across the wrist; no evidence of cervical radiculopathy on either side. She was evaluated on 04/23/2014 and it was documented the injured worker complained of low back pain that was reported as the same since last visit. The injured worker's pain was rated at 5/10 on the VAS measurement. Carpal tunnel syndrome was noted on the right greater than left. The injured worker was currently not working. Objective findings demonstrated tenderness to palpation with muscle spasm and range of motion. The injured worker had a positive straight leg raise. Lumbar spine range of motion was 30 degrees in flexion, 10 degrees extension, right and left bending was 15 degrees, right and left rotation was 15 degrees. Medications included ibuprofen, gabapentin and ranitidine. The lumbar spine MRI dated 04/15/2013, demonstrated slight changes of facet arthropathy developing at L4-5 and L5-S1, minimal posterior disc bulge of less than 2 mm without stenosis at L5-S1. The Request for Authorization was not submitted for this review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right L5 transforminal epidural steroid injection X3 with trigger point injection under fluroscopic guidance:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs), Trigger Point Injections & Criteria for the use of Trigger.

**Decision rationale:** The requested service is not medically necessary. The California Treatment Guidelines recommend epidural steroid injections as an option for treatment of radicular pain (defined as pain in dermatome distribution with corroborative findings of radiculopathy). Epidural steroid injection can offer short-term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electro diagnostic testing. Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). Additionally, failure to respond to conservative treatment is also a criterion for ESIs. California (MTUS) Chronic Pain Medical Guidelines recommends trigger point injections 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 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) for fibromyalgia syndrome, trigger point injections have not been proven effective. The guidelines also states trigger point injections may be used 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. The injured worker diagnoses included shoulder pain. The provider indicated the injured worker has received injections prior however, the outcome measurements were not provided. The documents submitted indicated the injured worker had conservative care however, the outcome measurements were not provided given the above, the request for right L5 transforminal epidural steroid injection X 3 with trigger point injection under fluoroscopic guidance is not medically necessary.