

<b>Case Number:</b>	CM14-0197734		
<b>Date Assigned:</b>	12/08/2014	<b>Date of Injury:</b>	10/16/2012
<b>Decision Date:</b>	01/21/2015	<b>UR Denial Date:</b>	10/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/25/2014

### 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 48-year-old man who sustained a work-related injury on October 16, 2012. Subsequently, the patient developed low back pain. Prior treatments included: physical therapy, anti-inflammatory medications, chiropractic care, lumbar epidural steroid injections (with some relief), Transcutaneous electrical nerve stimulation (TENS) unit (on April 18, 2014), and 4 trigger point injections (TPI) in the bilateral lumbosacral paraspinal muscles. According to the note dated October 30, 2014, the patient continued to have pain in the lumbosacral spine. Physical examination revealed decreased range of motion of the back by 10% in all planes; normal motor strength; normal reflexes in bilateral lower extremities; positive spasms in bilateral traps and lumbosacral spine; positive bilateral lumbosacral spine facet maneuver; straight leg raise negative; and positive bilateral trap trigger points. The patient was diagnosed with cervical spondylosis, lumbar strain/sprain, degenerative disc disease at L5-S1, thoracic spine pain, and probable cubital tunnel syndrome right. The provider requested authorization for TENS pad, Medial branch block bilateral L3, L4, L5, S1, and TPI times 4 to bilateral trapezius with 5cc 1% Lidocaine.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Transcutaneous electrical nerve stimulation (TENS) pad times 2 for cervical and lumbar region:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Percutaneous Electrical Nerve Stimulation Page(s): 97.

**Decision rationale:** According to MTUS guidelines, TENS is not recommended as primary treatment modality, but a one month based trial may be considered, if used as an adjunct to a functional restoration program. There is no evidence that a functional restoration program planned for this patient. Furthermore, there is no clear information about a positive one month trial of TENS. There is no recent documentation of recent flare of his pain. The provider should document how TENS will improve the functional status and the patient's pain condition. Therefore, the prescription of TENS pad is not medically necessary.

**Medial branch block bilateral L3, L4, L5, S1:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

**Decision rationale:** According MTUS guidelines, "Invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. Although epidural steroid injections may afford short-term improvement in leg pain and sensory deficits in patients with nerve root compression due to a herniated nucleus pulposus, this treatment offers no significant long term functional benefit, nor does it reduce the need for surgery. Despite the fact that proof is still lacking, many pain physicians believe that diagnostic and/or therapeutic injections may have benefit in patients presenting in the transitional phase between acute and chronic pain." Regarding facets injections, ODG guidelines state: "Under study. Current evidence is conflicting as to this procedure and at this time no more than one therapeutic intra-articular block is suggested. If successful (pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive). If a therapeutic facet joint block is undertaken, it is suggested that it be used in consort with other evidence based conservative care (activity, exercise, etc.) to facilitate functional improvement. (Dreyfuss, 2003) (Colorado, 2001) (Manchikanti, 2003) (Boswell, 2005) See Segmental rigidity (diagnosis). In spite of the overwhelming lack of evidence for the long-term effectiveness of intra-articular steroid facet joint injections, this remains a popular treatment modality. Intra-articular facet joint injections have been popularly utilized as a therapeutic procedure, but are not currently recommended as a treatment modality in most evidence-based reviews as their benefit remains controversial." Furthermore and according to ODG guidelines, "Criteria for use of therapeutic intra-articular and medial branch blocks, are as follows: 1. No more than one therapeutic intra-articular block is recommended. 2. There should be no evidence of radicular pain, spinal stenosis, or previous fusion. 3. If successful (initial pain relief of 70%, plus pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and

subsequent neurotomy (if the medial branch block is positive). 4. No more than 2 joint levels may be blocked at any one time. 5. There should be evidence of a formal plan of additional evidence-based activity and exercise in addition to facet joint injection. In this case, there is no documentation of facet mediated pain. There is no clear evidence or documentation that L3, L4, L5, and S1 facets are main pain generator. There is no evidence of a formal plan of additional evidence-based activity and exercise in addition to facet joint injection. MTUS guidelines do not recommend more than 2 joint levels to be blocked at any one time. Therefore, the request for Medial branch block bilateral L3, L4, L5, and S1 is not medically necessary.

**Trigger point injection (TPI) times 4 to bilateral trapezius with 5cc 1% Lidocaine:** Upheld

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

**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, non-steroidal anti-inflammatory drugs (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 Trapezius muscle. There is no documentation of failure of oral medications or physical therapy in this case. Therefore, the request for TPI times 4 to bilateral trapezius with 5cc 1% Lidocaine is not medically necessary.