

Case Number:	CM14-0201541		
Date Assigned:	12/11/2014	Date of Injury:	04/14/1999
Decision Date:	01/30/2015	UR Denial Date:	11/07/2014
Priority:	Standard	Application Received:	12/02/2014

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 injured worker is a seventy-two year old female who sustained a work-related injury on April 14, 1999. A request for four lumbar spine trigger point injections was non-certified in Utilization Review (UR) on November 7, 2014. The UR physician utilized the California (CA) MTUS guidelines in the determination. The CA MTUS recommends that trigger point injections with a local anesthetic be recommended for the treatment of chronic low back or neck pain with myofascial pain syndrome under specific criteria. The criteria includes documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain and documentation that medical management therapies such as ongoing stretching exercises, physical therapy, nonsteroidal anti-inflammatory medication and muscle relaxants have failed to control pain. The UR physician determined that the documentation submitted for review did not well-delineate circumscribed trigger points with evidence of twitch response and referred pain that had been present for greater than three months. The documentation did not identify the injured worker's participation and compliance with therapy such as ongoing stretching or utilization of nonsteroidal anti-inflammatory medications. A request for independent medical review (IMR) was initiated on December 1, 2014. The clinical documentation submitted for IMR included a physician's evaluation on May 19, 2014. The evaluating physician noted that the injured worker complained of continued low back pain which radiated down to her right lower extremity. She rated her pain a 6 on a 10-point scale. She had a lumbar epidural injection on December 12, 2013 which provided 3 months of benefit with improved mobility and activity tolerance. The injured worker used a lumbar spinal cord stimulation which was implanted on January 24, 2011 and reported significant improvement with her radicular symptoms. The injured worker had discontinued all narcotic pain medications and used only Ultram ER, Flex Mid, Lyrica, Anaprox and Prilosec. On examination, the injured

worker had tenderness to palpation and increased muscle rigidity bilaterally over the lumbar spine. She had numerous trigger points that were palpable and tender throughout the lumbar paraspinal muscles. She exhibited decreased range of motion in both lumbar flexion and extension. An MRI of the lumbar spine performed on July 16, 2010 revealed multi-level spondylosis, most significant at L4-5 and L5-S1. The evaluating physician documented that the injured worker had greater than three months of myofascial pain in the posterior lumbar musculature which medical management therapies such as ongoing stretching exercises, physical therapy and/or muscle relaxations have failed to control. The evaluating physician documented the injured worker had palpable trigger points with discrete focal tenderness located in a palpable taut band of skeletal muscle which produced a local twitch in response to stimulus to the band. The evaluating physician noted that the injections are occasionally necessary to maintain function and to help decrease medication use. The injured worker was administered four trigger-point injections and reported greater than 50% improvement in pain relief and an increased range.

IMR ISSUES, DECISIONS AND RATIONALES

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

Four lumbar spine trigger point injections: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger Point 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. 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 spine. Although the patient was reported to have trigger points, there is documentation of twitch response and referral pain. There is no documentation of failure of oral medications or physical therapy in this case. Therefore, the request for Lumbar Spine Trigger Point Injections is not medically necessary.