

<b>Case Number:</b>	CM14-0201881		
<b>Date Assigned:</b>	12/12/2014	<b>Date of Injury:</b>	09/27/2004
<b>Decision Date:</b>	02/03/2015	<b>UR Denial Date:</b>	11/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	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 Anesthesiology, has a subspecialty in Acupuncture & Pain 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:

49y/o female injured worker with date of injury 9/27/04 with related back pain. Per progress report dated 11/7/14, the injured worker reported severe back pain that radiated to the left arm and left foot. She described the pain as an ache, burning, piercing, shooting, and throbbing. She rated her pain without medications as 9/10 and 6/10 with medications. Physical exam findings were not documented. Treatment to date has included physical therapy, epidural steroid injections, functional restoration program, spinal cord stimulator trial, and medication management. The date of UR decision was 11/19/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **TRIGGER POINT INJECTION TO THE LUMBAR SPINE: Upheld**

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

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

**Decision rationale:** With regard to trigger point injections, the MTUS CPMTG states: Recommended only for myofascial pain syndrome as indicated below, with limited lasting value." "Criteria for the use of Trigger point injections: 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. (Colorado, 2002) (BlueCross BlueShield, 2004)"The medical records submitted for review do not contain documentation of circumscribed trigger points. The criteria are not met; the request is not medically necessary.

**ACUPUNCTURE x10 FOR THE LUMBAR SPINE:** Upheld

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

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

**Decision rationale:** Per Acupuncture Medical Treatment Guidelines p9, "(c) Frequency and duration of acupuncture or acupuncture with electrical stimulation may be performed as follows:(1) Time to produce functional improvement: 3 to 6 treatments.(2) Frequency: 1 to 3 times per week.(3) Optimum duration: 1 to 2 months.(d) Acupuncture treatments may be extended if functional improvement is documented as defined in Section 9792.20"With regard to acupuncture, ACOEM states "Acupuncture has not been found effective in the management of back pain, based on several high-quality studies, but there is anecdotal evidence of its success." ACOEM p309 gives needle acupuncture an optional recommendation for evaluating and managing low back complaints.As the request is in excess of the guideline recommended 6 sessions, medical necessity cannot be affirmed. It should be noted that the UR physician has certified a modification of the request for 6 treatments.