

Case Number:	CM15-0127702		
Date Assigned:	07/14/2015	Date of Injury:	08/29/1999
Decision Date:	11/12/2015	UR Denial Date:	06/18/2015
Priority:	Standard	Application Received:	07/01/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: North Carolina
 Certification(s)/Specialty: Family Practice

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 47 year old male with an industrial injury date of 08-29-1999. Medical record review indicates he is being treated for lumbago, pain in joint-lower leg, thoracic spondylosis without myelopathy and cervicgia. Subjective complaints (05-07-2015) included thoracic, low back, knee and neck pain. Physical exam (05-07-2015) noted the cervical spine was tender to palpation with limited range of motion. Palpation of the cervical facet revealed pain in cervical 3-cervical 7 regions on both the sides. There was pain with range of motion. Thoracic spine exam revealed tenderness noted at paraspinal muscles and facet joint lines. Range of motion was restricted with flexion and extension. Lumbar spine examination revealed lumbar facet pain on both sides of the lumbar 3-sacral 1 region. There was pain noted over the lumbar intervertebral spaces (discs) on palpation. Other findings noted pain with palpation of the bilateral sacroiliac and tenderness with palpation of the greater trochanteric bursa. There was pain with lumbar range of motion. Left knee exam noted tenderness in the patella of the left knee. The injured worker received trigger point injections to lumbar spine on 03-17-2015 and 05-15-2015. The treating physician documented; "The patient was feeling relief by the time the block had set." In the 04-15-2015 note, the injured worker was complaining of low back pain down his right leg and into both feet. The pain is documented as 5 out of 10, worst pain was 8-9 out of 10 and least pain was 3-4 out of 10. His medications included Hydrocodone, Soma and Alprazolam. Prior treatment included arthroscopy left knee, anterior cervical fusion, MS Contin and Norco ("both made him sick"), chiropractic, physical therapy, lumbar discogram, lumbar epidural steroid injections, knee and lumbar joint injections, lumbar radiofrequency ablation and

lumbar trigger point injections. The treatment request included: Retrospective request for lumbar spine trigger point injection, quantity: 1, preformed on 6/4/15. Retrospective request for left knee joint injection, quantity: 1, preformed on 6/4/15. On 06-18-2015, the treatment request listed below was non-certified by utilization review: Retrospective request for lumbar spine trigger point injection, quantity: 1, preformed on 6/4/15. Retrospective request for left knee joint injection, quantity: 1, preformed on 6/4/15.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for left knee joint injection, quantity: 1, preformed on 6/4/15:

Upheld

Claims Administrator guideline: Decision based on MTUS Knee Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Knee Complaints 2004, Section(s): Initial Care.

Decision rationale: The ACOEM chapter on knee complaints states: Invasive techniques, such as needle aspiration of effusions or prepatellar bursal fluid and cortisone injections, are not routinely indicated. Knee aspirations carry inherent risks of subsequent intraarticular infection. A reddened, hot, swollen area may be a sign of cellulitis or infected prepatellar bursitis; thus, aspirating the joint through such an area is not recommended because microorganisms may be introduced into a previously sterile joint space. If a patient has severe pain with motion, septic effusion of the knee joint is a possibility, and referral for aspiration, Gram stain, culture, sensitivity, and possibly lavage may be indicated. Initial atraumatic effusions without signs of infection may be aspirated for diagnostic purposes. There is a high rate of recurrence of effusions after aspiration, but the procedure may be worthwhile in cases of large effusions or if there is a question of infection in the bursa. Patients with recurrent effusions who have a history of gout or pseudogout may need aspiration to rule out infection, but more likely will need it only for comfort, if at all. Osteoarthritis can present with effusions, but findings of crepitus, palpable osteophytes, and history of chronic symptoms are usually sufficient to make the differential diagnosis. Swelling and sponginess anterior to the patella is consistent with a diagnosis of prepatellar bursitis. The patient does not have evidence of significant effusion on provided exam. There is no diagnosis of gout or complete failure of first line treatment options. Therefore, the request is not medically necessary.

Retrospective request for lumbar spine trigger point injection, quantity: 1, preformed on 6/4/15: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Trigger point injections.

Decision rationale: The California chronic pain medical treatment guidelines section on trigger point injections states: Trigger point injections-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) 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 provided clinical documentation fails to show circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain. Therefore, criteria have not been met and the request is not medically necessary.