

<b>Case Number:</b>	CM15-0217228		
<b>Date Assigned:</b>	11/09/2015	<b>Date of Injury:</b>	10/16/1999
<b>Decision Date:</b>	12/18/2015	<b>UR Denial Date:</b>	10/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/04/2015

### 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: Ohio, West Virginia

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Medical Toxicology

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 57 year old woman sustained an industrial injury on 10-16-1999. Diagnoses include post-laminectomy syndrome of the lumbar spine, cervicgia, sciatica, post-laminectomy syndrome of the cervical spine, myalgia and myositis, dysthymic disorder, and lumbago. Treatment has included oral medications, Botox injections, and cervical spine trigger point injections with short term relief. Physician notes dated 10-8-2015 show complaints of increased low back pain with radiation to the bilateral lower extremities, sciatica, and neck pain with cervicogenic headaches and radiation to the bilateral upper extremities as well as depression and anxiety. The physical examination shows tenderness to palpation of the bilateral greater trochanteric bursts. Cervical spine range of motion is 75-90% of normal across all planes and shows decreased pain with range of motion since the Botox injections. The lumbar spine shows loss of lordosis with range of motion 60-75% of normal across all planes with pain. Tender trigger points are noted in the low lumbar areas bilaterally as well as facet joint tenderness. Recommendations include Percocet, Tramadol, cervical and lumbar spine trigger point injections at each of next visits, Gabapentin, continue psychiatric care, Capsaicin patch, and follow up in one month. Utilization Review denied a request for cervical and lumbar trigger point injections on 10-16-2015.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Trigger point injections (TPIs) for the cervical and lumbar spine x 3: Upheld**

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

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

**Decision rationale:** MTUS states that Trigger Point Injections are "Recommended only for myofascial pain syndrome as indicated below, with limited lasting value. Not recommended for radicular pain." And further states that "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. For fibromyalgia syndrome, trigger points injections have not been proven effective." MTUS lists the criteria for Trigger Points:(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. MTUS specifically states that TPI is not recommended when radicular symptoms are present, as in this case. Further it is noted in the available medical record that this request is for repeat cervical TPI's, the pain relief level from the earlier injections is not documented. As such, the request for Trigger point injections (TPIs) for the cervical and lumbar spine x3 is not medically necessary.