

Case Number:	CM15-0035707		
Date Assigned:	03/04/2015	Date of Injury:	02/16/2012
Decision Date:	04/08/2015	UR Denial Date:	02/04/2015
Priority:	Standard	Application Received:	02/25/2015

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: California, Indiana, New York
Certification(s)/Specialty: Internal Medicine

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 38-year-old female who sustained an industrial related injury on 2/16/12. The injured worker had complaints of low back pain, intermittent leg pain, and muscle spasms across the low back. Diagnoses included degeneration of cervical intervertebral disc, degeneration of lumbar or lumbosacral intervertebral disc, displacement of lumbar intervertebral disc without myelopathy, thoracic or lumbar spondylosis with myelopathy, thoracic or lumbosacral neuritis or radiculitis, brachial neuritis or radiculitis, lumbar facet joint pain, cervical facet joint pain, gastroesophageal reflux disease, and insomnia. Treatment included trigger point injections in bilateral deep lumbar fascia and cervical radiofrequency rhizotomy. Medications included Zoloft, Trazodone, Nexium, Phenergan, and Tramadol. The treating physician requested authorization for a bilateral deep lumbar fascia trigger point injection. The utilization review physician cited the Medical Treatment Utilization Schedule guidelines and noted there was no evidence of circumscribed trigger points upon palpation with referred pain or evidence the injured what had failed initially recommended conservative treatment. Therefore the request was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral deep lumbar fascia trigger point injection: 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 based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back section, Trigger point injections.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, bilateral deep lumbar fascia trigger point injections are not medically necessary. Trigger point injections are not recommended in the absence of myofascial pain syndrome. The effectiveness of trigger point injections is uncertain, in part due to the difficulty of demonstrating advantages of active medication over injection of saline. Needling alone may be responsible for some of the therapeutic response. The only indication with some positive data is myofascial pain; may be appropriate when myofascial trigger points are present on examination. Trigger points are not recommended when there are radicular signs, but they may be used for cervicgia. The criteria for use of trigger point injections include circumscribed trigger points with evidence upon palpation of a twitch response; symptoms greater than three months; medical management therapies have failed to control pain; radiculopathy is not present; no more than three - four injections per session; no repeat injections unless a greater than 50% pain relief with reduced medication use is obtained for six weeks after injection and there is documented evidence of functional improvement; there should be evidence of ongoing conservative treatment including home exercise and stretching. Its use as a sole treatment is not recommended. TPIs are considered an adjunct, not a primary treatment. See the guidelines for additional details. In this case, the injured workers working diagnoses are degeneration of cervical inter-vertebral disc; degeneration lumbar or lumbosacral intervertebral disc; displacement lumbar disc without myelopathy; thoracic or lumbar spondylosis with myelopathy; thoracic or lumbosacral neuritis or radiculitis unspecified; brachial neuritis or radiculitis; lumbar facet joint pain; cervical facet joint pain; and gastroesophageal reflux disease. Subjectively, the injured worker admits to a history of constant aching low back pain with intermittent leg pain associated with frequent muscle spasms across the low back and lumbosacral aching pain. Objectively, the treating physician states, there are no objective signs of radiculopathy. The treating physician documents a diagnosis of lumbosacral neuritis or radiculitis unspecified. The guidelines do not distinguish between objective and subjective radicular findings when considering exclusion criteria. The injured worker has complaints of subjective intermittent radiculopathy with a diagnosis confirming the subjective complaints. Consequently, absent clinical documentation of non-radicular pain, bilateral deep lumbar fascia trigger point injections are not medically necessary.