

<b>Case Number:</b>	CM13-0037573		
<b>Date Assigned:</b>	12/18/2013	<b>Date of Injury:</b>	03/15/2012
<b>Decision Date:</b>	01/19/2015	<b>UR Denial Date:</b>	10/11/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/23/2013

### 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 Preventive Medicine, has a subspecialty in Occupational Medicine and is licensed to practice in Iowa. 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:

This is a 55 year old patient with date of injury of 09/15/2011. Medical records indicate the patient is undergoing treatment for status post L5-S1 fusion, cervical spasm, cervical radiculitis, neck pain, lower back pain, l4-5 facet arthropathy, L3-4 and L4-5 disc protrusions, C5-6 and C6-7 disc protrusion, spasm of muscle, brachial neuritis or radiculitis, cervicgia and lumbago. Subjective complaints include bilateral neck pain rated 8/10; mid-back/thoracic pain, difficulty sleeping, radicular symptoms in legs and axial back pain is worsening. Objective findings include cervical range of motion (ROM) - flexion 30 degrees, extension 30, right lateral rotation 30, left lateral rotation 40, left lateral bending 30 and right lateral bending 35. The patient has a positive Spurling's on the right and palpable muscle spasms across the neck paracervical and upper trapezius with trigger points identified; increased pain on extension and rotation with tenderness over the facet joints. The patient's lumbar range of motion - flexion 65, extension 20, right and left lateral rotation are normal, right and left lateral bending are within normal limits. There are palpable muscle spasms across lower lumbar region, increased pain on lumbar extension and tenderness over the facet joints; hyperkyphosis of the thoracic spine; tenderness over the sacroiliac joints and sciatic notches bilaterally, left greater than right. X-ray of cervical spine 02/07/2013 revealed normal cervical spine. MRI of cervical spine dated 02/07/2013 revealed a mild 2mm disc bulge/protrusion, no central canal or neural foraminal stenosis, otherwise normal cervical spine MRI. Treatment has consisted of Lumbar MBRFA (7/2013), water therapy, visits with pain management, psychotherapy, Lexapro, Xanax, Klonopin, Zoloft, Lodine, Toradol and Flexeril. The utilization review determination was rendered on 10/11/2013 recommending non-certification of Retrospective Repeat Trigger Point Injections to the Paracervical Region x3 with 3ml of 0.25% Marcaine (DOS 9/18/13) and Right Sided C3-4, C4-5, and C5-6 Facet Blocks.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Retrospective Repeat Trigger Point Injections to the Paracervical region x3 with 3ml of 0.25% Marcaine (DOS 9/18/13): 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:** 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 radiculopathy should not be present by exam, imaging, or neuro-testing. However, the treating physician has documented the presence of radiculopathy. As such, the request for Retrospective Repeat Trigger Point Injections To the paracervical region x3 with 3ml OF 0.25% Marcaine (DOS 9/18/13) is not medically necessary.

### **Right Sided C3-4, C4-5, and C5-6 Facet Blocks: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back; Facet joint diagnostic blocks (injections).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315, Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: MD Guidelines, Facet Joint Injections/Therapeutic Facet Joint Injections

**Decision rationale:** ACOEM Guidelines state "Invasive techniques (e.g., local injections and facet-joint injections of cortisone and Lidocaine) are of questionable merit. Although epidural steroid injections may afford short-term improvement in leg pain and sensory deficits in patients

with nerve root compression due to a herniated nucleus pulposus, this treatment offers no significant long term functional benefit, nor does it reduce the need for surgery. Despite the fact that proof is still lacking, many pain physicians believe that diagnostic and/or therapeutic injections may have benefit in patients presenting in the transitional phase between acute and chronic pain." MTUS is silent specifically with regards to facet injections, but does refer to epidural steroid injections. ODG and MD Guidelines agree that: "One diagnostic facet joint injection may be recommended for patients with chronic low back pain that is significantly exacerbated by extension and rotation or associated with lumbar rigidity and not alleviated with other conservative treatments (e.g., NSAIDs, aerobic exercise, other exercise, manipulation) in order to determine whether specific interventions targeting the facet joint are recommended if after the initial block/blocks are given (see "Diagnostic Phase" above) and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be supported." ODG details additional guidelines: Clinical presentation should be consistent with facet joint pain, signs & symptoms.1. One set of diagnostic medial branch blocks is required with a response of; the pain response should last at least 2 hours for Lidocaine.2. Limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally.3. There is documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks.4. No more than 2 facet joint levels are injected in one session (see above for medial branch block levels).5. Recommended volume of no more than 0.5 cc of injectate is given to each joint.6. No pain medication from home should be taken for at least 4 hours prior to the diagnostic block and for 4 to 6 hours afterward.7. Opioids should not be given as a "sedative" during the procedure.8. The use of IV sedation (including other agents such as midazolam) may be grounds to negate the results of a diagnostic block, and should only be given in cases of extreme anxiety.9. The patient should document pain relief with an instrument such as a VAS scale, emphasizing the importance of recording the maximum pain relief and maximum duration of pain. The patient should also keep medication use and activity logs to support subjective reports of better pain control.10. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated. (Resnick, 2005)11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. [Exclusion Criteria that would require UR physician review: Previous fusion at the targeted level. The treating physician does not provide imaging studies that support the diagnoses of facet arthropathy and the requested number of injections is for 3 facet levels, exceeding the guideline recommendations of no more than 2 facet levels. As such, the request for Right Sided C3-4, C4-5, and C5-6 Facet Blocks is not medically necessary.