

Case Number:	CM14-0140795		
Date Assigned:	09/10/2014	Date of Injury:	05/30/2003
Decision Date:	02/26/2015	UR Denial Date:	08/22/2014
Priority:	Standard	Application Received:	09/02/2014

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. 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: New Jersey, Michigan, California

Certification(s)/Specialty: Neurology, Neuromuscular 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 patient is a 50-year-old woman who sustained a work-related injury on May 30, 2003. Subsequently, she developed low back pain. Prior treatments included: back brace, physical therapy, work restrictions, and medications. MRI of the lumbar spine dated October 8, 2008 showed small disc protrusion at L5-S1, slightly deviating the course of the descending left S1 nerve root but not impinging it. This had progressed since 2003. There was no change in the small central L4-5 disc protrusion. AMG/NCS performed on June 14, 2006 documented electrodiagnostic evidence for chronic left L5 lumbar radiculopathy without active denervation. There was no electrodiagnostic evidence for right lumbosacral radiculopathy or peripheral neuropathy. According to the progress report dated May 27, 2014, the patient complained of lower back pain. She rated the level of her pain as a 9/10 with medication and 10/10 without medication. She reported the quality of her sleep was poor. She continued to report daily heartburn. She stopped Ibuprofen on May of 2014 and she is now taking Prilosec. Examination of the lumbar spine revealed a restricted range of motion with flexion limited to 65 degrees limited by pain, extension limited to 12 degrees limited by pain, but normal right lateral bending and left lateral bending. On palpation, paravertebral muscles, spasm, tenderness and tight muscle band were noted on both sides. No spinal process tenderness was noted. Lumbar facet loading was positive on both sides. Ankle jerk was on both sides. Patellar jerk was 2/4 on both sides. Motor strength of EHL was 5/5 on right and 4/5 on left, ankle dorsi flexion was 5/5 on right and 4/5 on left, knee extensor's was 5/5 on both sides, knee flexor's was 5/5 on both sides, hip flexor's was 5/5 on both sides. On sensory examination, light touch sensation was decreased over the L5

lower extremity dermatomes on the left side. Straight leg raising test was positive on the left side. The patient was diagnosed with spinal/ lumbar DDD, lumbar radiculopathy, and spasm of muscle. The provider requested authorization for MRI lumbar spine without contrast, spine surgeon consultation/evaluation, and lumbar trigger point injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar Trigger Point Injection x1: Upheld

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

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

Decision rationale: According to MTUS guidelines, trigger point injection is 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) 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. There is no clear evidence of myofascial pain and trigger points over the lumbar and sciatic notch. There is no documentation of failure of oral medications or physical therapy in this case. Therefore, the request for lumbar Trigger point injection is not medically necessary.