

Case Number:	CM14-0210460		
Date Assigned:	12/23/2014	Date of Injury:	01/23/2010
Decision Date:	02/20/2015	UR Denial Date:	11/26/2014
Priority:	Standard	Application Received:	12/16/2014

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 52-year-old man who sustained a work-related injury on January 23, 2010. Subsequently, he developed low back pain. The patient is status post anterior lumbar interbody fusion in 2006 following spondylolisthesis and parts defect at L3-4. His pain improved following surgery. However, on January 23, 2010 the patient experienced acute onset of abdominal pain and flank pain, which turned out to be instrumentation failure. The patient underwent posterior fusion in 2010. He also had a migrated screw, which could not be retrieved during surgery. Since surgery, the patient reported impotence, paresthesia, and feet numbness in addition to back and leg pain. Lumbar MRI dated September 2, 2014 showed chronic degenerative and postoperative changes of the lumbar spine. Mild to moderate spinal stenosis at L3-4. Additional levels of spinal stenosis were noted at T12-L1, L1-L2. Bilateral L3 pars defects. Severe bilateral foraminal narrowing at L3-4 as well as other multilevel foraminal narrowing T12-L1 and L1-2. According to the progress report dated December 3, 2014, the patient reported that his current level of pain was 4/10. The patient continued to use the TENS for break-through pain. It was noted that his provider did recommend injections and have not been approved. At his last visit, the patient did receive toradol injection, which provided good relief for 3 days. Objective findings included: diminished sensation at L1, L2, L3, and L5-S1; weakness throughout the lower extremity; motor exam 4/5 in all groups due to pain. Reflexes were decreased at over the bilateral patellar tendons; pain with lumbar flexion and extension at 45 degrees and 10 degrees respectively; pain over the lumbar spine to palpation. The patient was diagnosed with postlaminectomy syndrome, lumbar radiculitis radiculopathy, low back pain, and intervertebral

disc disorder. The provider requested authorization for bilateral trigger point injections under ultrasound guidance lumbar/sacral.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral Trigger Point Injections under Ultrasound Guidance Lumbar/Sacral: 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), Section 722.1, subsection Trigger Point Injections (TPI).

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 Bilateral Trigger Point Injections under Ultrasound Guidance Lumbar/Sacral is not medically necessary.