

<b>Case Number:</b>	CM14-0082670		
<b>Date Assigned:</b>	07/23/2014	<b>Date of Injury:</b>	05/30/1989
<b>Decision Date:</b>	06/01/2015	<b>UR Denial Date:</b>	05/12/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/04/2014

### 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: North Carolina  
 Certification(s)/Specialty: Family Practice

### 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 61-year-old male with an industrial injury date of 05/30/1989. His diagnoses included lumbar radiculopathy, lumbar spine, and unspecified internal derangement of knee, lumbar spinal stenosis, degenerative disc disease, lumbar spondylosis and fibromyalgia / myositis. Prior treatments included bilateral lumbar 4-5 epidural steroid injection, diagnostics and medications. She presents on 05/01/2014 with back and leg pain. Physical exam revealed moderate stiffness and muscle spasm of paralumbar thoracic regions. Palpable twitch positive trigger points were noted in the lumbar paraspinal muscles. There was pain with anterior and posterior lumbar extension. The provider documents the injured worker had more than 60% relief with bilateral lumbar 4-5 epidural injection done on 02/17/2014. Treatment plan included trigger point injection and repeat bilateral transforaminal lumbar 4-5 epidural steroid injection.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**One (1) Transforaminal Epidural Injections (ESI) at Lumbar 4-5 under Fluoroscopy and Anesthesia:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs). Decision based on Non-MTUS Citation Anderson GBJ, Cocchiarella, L American Medical Association, Guides to the Evaluation of Permanent Impairment, Fifth Edition. Hardcover-Dec 15, 2000. (page 382-383).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines epidural steroid injection Page(s): 46.

**Decision rationale:** The California chronic pain medical treatment guidelines section on epidural steroid injections (ESI) states: Criteria for the use of Epidural steroid injections: Note: The purpose of ESI is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections. 5) No more than two nerve root levels should be injected using transforaminal blocks. 6) No more than one interlaminar level should be injected at one session. 7) In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007) 8) Current research does not support a 'series-of-three' injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. The provided clinical documentation meets criteria as outlined above and therefore the request is certified.

**Five (5) Trigger Point Injections:** Overturned

**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:** The California chronic pain medical treatment guidelines section on trigger point injections states: Trigger point injections. 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 upto 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) Criteria for the use of Trigger point injections: 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. (Colorado, 2002) (BlueCross BlueShield, 2004) The provided clinical documentation shows circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain. Therefore, criteria have been met and the request is certified.