

<b>Case Number:</b>	CM15-0001696		
<b>Date Assigned:</b>	01/12/2015	<b>Date of Injury:</b>	02/03/2014
<b>Decision Date:</b>	03/11/2015	<b>UR Denial Date:</b>	12/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/05/2015

### 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  
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 47-year-old male with an injury date of 02/03/14. Based on the 11/17/14 progress report provided by treating physician, the patient complains of pain, rated 07/10, in the lower back bilaterally. When under control, pain is 04/10. Lumbar spine physical examination to of the paravertebral muscle on 11/17/14 showed hypertonicity, spasm, tenderness, tight muscle band, and trigger point on both sides. Straight leg test was positive. Patient's treatments include physical therapy and TENS unit with moderate relief and exercise with no relief. Prior diagnostic studies include X-rays on 02/14 and MRI of the back on 04/02/14, which revealed posterior disk protrusion at L4-5. Per the UR letter dated 12/04/14, the patient underwent an electrodiagnostic testing on 05/07/14 which demonstrated a normal study. Concurrent medications include Naprosyn and Ultram. Patient was permitted work with permanent restrictions but was rendered permanent and stationary as his work did not accommodate restrictions. Diagnosis 11/17/14- Facet arthropathy, lumbar-Radiculopathy, thoracic or lumbar-Spondylosis w/o myelopathy, lumbarThe utilization review determination being challenged is dated 12/04/14. The rationale follows: 1) ESI X1 AT L5-S1: 'electrodiagnostic testing was negative for objective evidence of lumbar radiculopathy...' 2) Bilateral Lumbar Trigger Point Qty 2: '...there are no special circumstances for this patient to support the need for injections to be performed at a surgical center' Treatment reports were provided from 03/05/14 - 11/17/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ESI x 1 at L5-S1: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Epidural Steroid Injection

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections Page(s): 46-47.

**Decision rationale:** The patient presents with complains of pain, rated 07/10, in the lower back bilaterally. When under control, pain is 04/10. The request is for ESI X1 AT L5-S1. Patient's diagnosis on 11/17/14 included facet arthropathy, lumbar, radiculopathy, thoracic or lumbar, and spondylosis w/o myelopathy, lumbar. Of note, per the UR letter dated 12/04/14, the patient underwent an electrodiagnostic testing on 05/07/14 which demonstrated a normal study. Patient was permitted work with permanent restrictions but was rendered permanent and stationary as his work did not accommodate restrictions. MTUS has the following regarding ESIs, under its chronic pain section: Page 46,47: "Criteria for the use of Epidural steroid injections: 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. 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." Treater is requesting one ESI to L5-S1. In review of the medical records, it does not appear that the patient has had any prior ESI treatments. Guidelines state that radiculopathy must be noted on examination and corroborated by MRI and/or electrodiagnostic testing. In this case, although the patient appears to demonstrate some evidence of radicular complains on exam, there is no clear description of the subjective radicular complaints that are corroborated by MRI, objective exam, and EMG/NCV. Given the lack of a clear documentation supporting radiculopathy, with corroboration and imaging studies as required by MTUS, the request IS NOT medically necessary.

**Bilateral Lumbar Trigger Point Qty: 2: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Trigger Point Injection. Decision based on Non-MTUS Citation ODG, Trigger Point Injection

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Trigger point injections Page(s): 122.

**Decision rationale:** The patient presents with complains of pain, rated 07/10, in the lower back bilaterally. When under control, pain is 04/10. The request is for BILATERAL LUMBAR TRIGGER POINT QTY 2. Lumbar spine physical examination to of the paravertebral muscle on 11/17/14 showed hypertonicity, spasm, tenderness, tight muscle band, and trigger point on both sides. Patient's treatments include physical therapy and TENS unit with moderate relief and exercise with no relief. Concurrent medications include Naprosyn and Ultram. Patient was permitted work with permanent restrictions but was rendered permanent and stationary as his

work did not accommodate restrictions. MTUS Guidelines, page 122, CHRONIC PAIN MEDICAL TREATMENT GUIDELINES support trigger point injections for "Documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain"; radiculopathy is not present, maximum of 3-4 injections per session, and for repeat injections, documentation of "greater than 50% pain relief is obtained for six weeks after an injection and there is documented evidence of functional improvement." Per progress reports dated 11/17/14, the patient meets the criteria which indicate that trigger point injections could be medically appropriate per MTUS: Documentation of circumscribed trigger points with referred pain, symptoms which persist greater than 3 months, and the failure of more conservative methods such as NSAIDS and physical therapy to resolve symptoms. There is no documentation supporting radiculopathy. The request for two injections is supported by the guidelines. This patient appears to meet the criteria for trigger point injections. This request IS medically necessary.