MAXIMUS Federal Services

Case Number:	CM15-0168619		
Date Assigned:	09/09/2015	Date of Injury:	06/17/2009
Decision Date:	11/12/2015	UR Denial Date:	08/11/2015
Priority:	Standard	Application Received:	08/27/2015

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: Hawaii, California, Iowa
Certification(s)/Specialty: Preventive Medicine, Occupational 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 injured worker is a 47 year old female, who sustained an industrial injury on 6-17-09. The injured worker was diagnosed as having lumbar spine (HNP) herniated nucleus pulposus, lumbar spine radiculopathy anxiety and bilateral sacroiliac joint pain. Treatment to date has included oral medications including Naproxen and Baclofen; trigger point injections and activity modifications. Currently on 7-8-15, the injured worker complains of continued low back pain rated 7 out of 10 which is 10% worse than last visit. She notes medications and trigger point injections are helpful. She is currently not working. Physical exam performed on 7-8-15 revealed tenderness to palpation of lumbar spine at L4-5 with slightly restricted range of motion. A request for authorization was submitted on 7-31-15 for 3 follow up visits, urinalysis, 4 trigger point injections and 3 facet injections. On 8-11-15, utilization review modified follow up office visits from 3 to 2, non-certified trigger point injections noting there is no documentation of chronic low back pain with myofascial pain syndrome and non-certified facet injections noting evidence based guidelines necessitate documentation of no previous fusion procedure at the planned injection level and no more than 2 joint levels to be injected in one session along with documentation of low back pain that is non-radicular.

IMR ISSUES, DECISIONS AND RATIONALES

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

Follow-up office visits X 3: 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), Office Visits.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain programs, early intervention Page(s): 32-33.

Decision rationale: The MTUS does not address the frequency of office visits. The Official Disability Guidelines, cited above, recommend office visits as medically necessary. Relevant factors include patient-specific clinical factors, medications, and achieving independence from the health care system. The MTUS, in the chronic pain section, provides direction for treating chronic pain, including a focus on functional improvement and return to work. The treating physician reports are brief, provide no work status, provide only the most minimal of information regarding the medical necessity for the proposed treatments, and do not discuss the indications and results regarding any of the medications. The medical necessity for follow-up visits was not discussed. There is no clear plan for functional improvement and the available reports seem to imply frequent office visits, as often as monthly for this injury from 2009. The current treatment plan is not supported by the MTUS and the other cited guidelines (see decisions below). The lack of evidence for a treatment plan for functional improvement mitigates against frequent office visits that do not lead to independence from the continued medical treatment (one of the factors in functional improvement per the MTUS). Based on the available records, 3 additional visits with this provider in order to further the passive care plan and continued disability is not medically necessary.

Facet injections L4, L5 X 3: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Criteria for the use of diagnostic blocks for facet "medicated" pain.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Facet joint intra-articular injections (therapeutic blocks) (http://worklossdatainstitute.verioiponly.com/odgtwc/low_back.htm#Facetjointinjections).

Decision rationale: According to ODG guidelines regarding facets injections, under study. Current evidence is conflicting as to this procedure and at this time no more than one therapeutic intra-articular block is suggested. If successful (pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive). If a therapeutic facet joint block is undertaken, it is suggested that it be used in consort with other evidence based conservative care (activity, exercise, etc.) to facilitate functional improvement. (Dreyfuss, 2003) (Colorado, 2001) (Manchikanti, 2003) (Boswell, 2005) See Segmental rigidity (diagnosis). In spite of the overwhelming lack of evidence for the long-term effectiveness of intra-articular steroid facet joint injections, this remains a popular treatment modality. Intra-articular facet joint injections

have been popularly utilized as a therapeutic procedure, but are not currently recommended as a treatment modality in most evidence-based reviews as their benefit remains controversial. Furthermore and according to ODG guidelines, Criteria for use of therapeutic intra-articular and medial branch blocks, are as follows: 1. No more than one therapeutic intra-articular block is recommended. 2. There should be no evidence of radicular pain, spinal stenosis, or previous fusion. 3. If successful (initial pain relief of 70%, plus pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive). 4. No more than 2 joint levels may be blocked at any one time. 5. There should be evidence of a formal plan of additional evidence-based activity and exercise in addition to facet joint injection. There is no documentation that the lumbar facets are the, main pain generator in this case. The diagnosis of radiculopathy was not excluded in this case. Therefore, the request for Facet injections L4, L5 X 3 is not medically necessary.

Trigger point injection X 4: 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 and regarding shoulder pain, Invasive techniques have limited proven value. If pain with elevation significantly limits activities, a subacromial injection of local anesthetic and a corticosteroid preparation may be indicated after conservative therapy (i.e., strengthening exercises and nonsteroidal anti-inflammatory drugs) for two to three weeks. The evidence supporting such an approach is not overwhelming. The total number of injections should be limited to three per episode, allowing for assessment of benefit between injections. Furthermore and 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 Trigger point injection X 4 is not medically necessary.