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| <b>Case Number:</b>   | CM15-0098994 |                              |            |
| <b>Date Assigned:</b> | 06/01/2015   | <b>Date of Injury:</b>       | 07/30/2007 |
| <b>Decision Date:</b> | 07/01/2015   | <b>UR Denial Date:</b>       | 05/13/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 05/22/2015 |

### 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: 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 57 year old male, who sustained an industrial injury on 7/30/2007. He reported low back and knee pain. The injured worker was diagnosed as having neck, low back and right lower extremity pain after lifting a heavy object. Treatment to date has included medications, urine drug screening, and lumbar epidural steroid injection. The request is for acupuncture, and trigger point injections of the cervical and lumbar spines. On 2/20/2015, he complained of diffuse neck pain, low back and right lower extremity pain. He indicated his pain to be severe in intensity without regular treatment, and is exacerbated by prolonged activity. The treatment plan included: Cyclobenzaprine, Gabapentin, Omeprazole, Hydroxyzine Pam, Nortriptyline Hcl, and Norco. The records are not clear there is myofascial pain. The records do not indicate failure of medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Trigger point injection cervical spine Qty: 1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 122.

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

**Decision rationale:** The MTUS Guidelines recommend the use of trigger point injections for myofascial pain syndrome as indicated, with limited lasting value. It is 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. 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. Trigger point injections are not recommended for typical back pain or neck pain. For fibromyalgia syndrome, trigger point injections have not been proven effective. 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 evidence in the available documentation that the injured worker is suffering from myofascial pain syndrome with associated trigger points in the cervical spine. The request for trigger point injection cervical spine Qty: 1 is determined to not be medically necessary.

**Trigger point injection lumbar spine Qty: 1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 122.

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

**Decision rationale:** The MTUS Guidelines recommend the use of trigger point injections for myofascial pain syndrome as indicated, with limited lasting value. It is 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. 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. Trigger point injections are not recommended for typical back pain or neck pain. For fibromyalgia syndrome, trigger point injections have not been proven effective. 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 evidence in the available documentation that the injured worker is suffering from myofascial pain syndrome with associated trigger points in the lumbar spine. The request for trigger point injection lumbar spine Qty: 1 is determined to not be medically necessary.

**Acupuncture 6 sessions to cervical and lumbar spine, right lower extremity: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** The MTUS Guidelines recommend the use of acupuncture in the treatment of chronic pain to improve function. The recommended time to produce functional improvement is 3 to 6 sessions at a frequency of 1 to 3 times per week over 1 to 2 months. Additional treatments may be necessary if there is documented functional improvement as a result to the trial of 3 to 6 sessions. The injured worker has had chronic pain for many years. There have been acupuncture sessions approved in the past but there is not clinical documentation of the efficacy of these treatments. There is no indication that the injured workers pain has changed requiring additional acupuncture treatments. The request for Acupuncture 6 sessions to cervical and lumbar spine, right lower extremity is determined to not be medically necessary.