

Case Number:	CM13-0051350		
Date Assigned:	06/09/2014	Date of Injury:	01/24/2013
Decision Date:	08/07/2014	UR Denial Date:	10/12/2013
Priority:	Standard	Application Received:	11/14/2013

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. The expert reviewer is Board Certified in Neurology, has a subspecialty in Neuromuscular Medicine and is licensed to practice in New Jersey. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 34-year-old woman who sustained a work-related injury on January 24, 2013. Subsequently she developed chronic neck pain. According to a progress report dated on June 10, 2014 the patient describes her pain as constant and moderate. It starts in the neck and radiates to the bilateral upper limbs and head to the eyes. Periodically, she gets severe stabbing pain. The pain is exacerbated by head flexion and extension. Her physical examination showed tenderness with palpation in the right and left shoulder, paracervical region, suboccipital ridge, and through the trapezius. The neck rotation to the left and right is 30 degrees. Neck flexion is 10-20 degrees with pain in the back of the neck. Neck extension is 20-30 degrees. Abduction is painful and difficult at 5-10 degrees bilaterally. Sensory exam showed decreased sensation through the tricep, lateral aspect of the forearm, and 4th and 5th fingers, left greater than right. Motor exam was 4/5 in the bicep and triceps with guarding and pain. Bicep reflexes are 2+. Tricep reflexes are 2-3+. BR reflexes are 1+. Knee reflexes are 2+. Ankle reflexes are 1-2+. Jamar reading is 30, 35, 28 on the right and 22, 25, 30 on the left. Her MRI showed right paracentral protrusion C4-5 without significant neural compression. The patient assessment was:-Spondylosis, cervical without Myelopathy. Post traumatic cervical musculoligamentous spasms/strain with confirmed loss of cervical lordosis on recent MRI corresponding to traumatic disc fissuring and traumatic disruption of the annulus fibrosis at the C4-5 level.-Associated cervical tension headaches secondary to above. The patient has been on TTD since March 2014 and she uses TENs daily. She has undergone physical therapy and acupuncture. Her medication included: Tramadol, hydrocodone, Relafen, and amitriptyline. The provider requested authorization for TRIGGER POINT INJECTION, CERVICAL EPIDURAL STEROID INJECTION, and cervical pillow.

IMR ISSUES, DECISIONS AND RATIONALES

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

TRIGGER POINT INJECTION: 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, 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. There is no documentation from the patient file that she have 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. Therefore, the request for TRIGGER POINT INJECTIONS is not medically necessary.

CERVICAL EPIDURAL STEROID INJECTION @ C7-T1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173, 309.

Decision rationale: According to MTUS guidelines, cervical epidural corticosteroid injections are of uncertain benefit and should be reserved for patients who otherwise would undergo open surgical procedures for nerve root compromise. Epidural steroid injection is optional for radicular pain to avoid surgery. It may offer short term benefit, however there is no significant long term benefit or reduction for the need of surgery. Furthermore, the patient file does not document that the patient is candidate for surgery. In addition, there is no clinical and objective documentation of radiculopathy. Her physical examination and MRI of the cervical spine do not support the diagnosis of cervical radiculopathy. There is no recent EMG or MRI studies as well as other clinical findings supporting the diagnosis of radiculopathy. MTUS guidelines does not recommend epidural injections for neck pain without radiculopathy (309).

CERVICAL PILLOW: 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), Neck Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pillow, <http://www.worklossdatainstitute.verioiponly.com/odgtwc/neck.htm>.

Decision rationale: According to ODG guidelines, pillow is Recommend use of a neck support pillow while sleeping, in conjunction with daily exercise. This RCT concluded that subjects with chronic neck pain should be treated by health professionals trained to teach both exercises and the appropriate use of a neck support pillow during sleep; either strategy alone did not give the desired clinical benefit. (Helewa, 2007). There is no documentation that the cervical pillow is prescribed in conjunction with daily exercise. Therefore, the prescribed cervical pillow is not medically necessary.