

Case Number:	CM14-0010261		
Date Assigned:	02/21/2014	Date of Injury:	12/17/2004
Decision Date:	08/01/2014	UR Denial Date:	01/03/2014
Priority:	Standard	Application Received:	01/27/2014

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. The expert reviewer is Board Certified in Occupational Medicine, and is licensed to practice in California. 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:

This is 53-year-old male patient with a 12/17/04 date of injury. He injured himself when he got in a MVA while driving a police car. A 1/6/10 progress report indicated that the patient continued to have jaw pain, 7/10 and the lower back, 5/10. He also continued to have migraines, which started on his right jaw and moved over his head and behind his eyes. Objective findings revealed mild tenderness to palpation over the bilateral TMJs. There was abnormal TMJ displacement when he opened his jaw. Physical exam of the lumbar spine demonstrated tenderness over bilateral lumbar paraspinal musculature. There was decreased sensation to light touch on the distal lateral lower extremity. He was diagnosed with TMJ dysfunction, lumbar spine facet joint syndrome, lumbar radiculitis radiculopathy and muscle spam. Treatment to date: medication management, ESI, trigger point injections and sphenopalatine ganglion block. The patient had 7 lumbar epidural steroid injections. The last one was on 5/15/13 with 75% pain relief for lower back for 5 months. A sphenopalatine ganglion block was done on 3/13/13 with 50-60% pain relief with headaches, and decreased pain sensation with jaw movements for 4 months. He also had successful trigger point injections for right trapezial pain. There is documentation of a previous 1/3/14 adverse determination, based on the fact that guidelines do not support repeated administration of intramuscular injections of anesthetic agents or steroids for treatment of chronic myofascial dysfunction. Because of limited feedback from the previous ESI, the next ESI was not certified. The sphenopalatine ganglion blockade was not certified based on the fact that there were no objectively stated sustainable therapeutic benefits of the previous procedure.

IMR ISSUES, DECISIONS AND RATIONALES

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

BILATERAL TRIGGER POINT INJECTIONS UNDER ULTRASOUND: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

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

Decision rationale: MTUS criteria for trigger point injections include chronic low back or neck pain with myofascial pain syndrome with circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain; symptoms for more than three months; medical management therapies have failed; radiculopathy is not present; and no more than 3-4 injections per session. Additionally, repeat injections are not recommended unless greater than 50% pain relief has been obtained for six weeks following previous injections, including functional improvement. However, there was no documentation of duration of functional benefits from the prior trigger point injections. There was no documentation of failure of medication management. In addition, he was diagnosed with lumbar radiculitis radiculopathy. Guideline does not recommend trigger point injections with radiculopathy. In addition, there was no description of circumscribed trigger points with evidence upon palpation of a twitch response. In addition, it is unclear why an ultrasound would be required for this procedure. Therefore, the request for bilateral trigger point injections under ultrasound is not medically necessary.

LUMBAR 4-5 EPIDURAL STEROID INJECTION (ESI) WITH SEDATION: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: AMA Guides (Radiculopathy).

Decision rationale: CA MTUS does not support epidural injections in the absence of objective radiculopathy. In addition, CA MTUS criteria for the use of epidural steroid injections include an imaging study documenting correlating concordant nerve root pathology; and conservative treatment. Furthermore, repeat blocks should only be offered if there is at least 50-70% pain relief for six to eight weeks following previous injection, with a general recommendation of no more than 4 blocks per region per year. The patient presented with pain in lower back, 5/10. However, he had seven previous epidural steroid injections. The last one was on 5/15/13 and gave the patient 75% pain relief in lumbar spine pain for 5 months. In addition, the patient was diagnosed with lumbar radiculitis and radiculopathy. Therefore, the request for lumbar 4-5 epidural steroid injection (ESI) with sedation is medically necessary.

SPHENOPALATINE GANGLION BLOCK WITH SEDATION: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Waldman's Interventional Pain Management, 2nd Edition.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Online articles.

Decision rationale: CA MTUS does not address this issue. Sphenopalatine ganglion (SPG) blockade has been evaluated for CH treatment. Of 20 refractory CCH patients who underwent the procedure, 11 experienced significant, albeit temporary, symptom relief. The optimum results of treatment are seen after six to eight weeks. A sphenopalatine ganglion block is done to diagnose the cause of pain in the face and head, manage the pain of, certain types of chronic headaches, and manage sympathetically maintained facial pain. The patient had jaw displacement and migraines that started with jaw pain. Sphenopalatine ganglion blocks are supported in the setting of chronic pain. In addition, there was documentation supporting the fact that the patient had 50-60% pain relief with headaches, decreased pain sensation with jaw movements for 4 months after the previous sphenopalatine ganglion blockade. Therefore, the request for sphenopalatine ganglion block with sedation is medically necessary.