MAXIMUS Federal Services

Case Number:	CM14-0117607		
Date Assigned:	08/06/2014	Date of Injury:	09/25/2012
Decision Date:	09/10/2014	UR Denial Date:	07/09/2014
Priority:	Standard	Application Received:	07/25/2014

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 Anesthesiology, Pain Medicine and is licensed to practice in Florida. 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 injured worker is a 50-year-old female who reported injury on 09/25/2012 reportedly sustaining injury to her head, neck, shoulders, low back, buttocks and legs while working as a machine operator. She stated when she opened up her door to grab some metal parts, the cabinet tilted and fell towards the injured worker. The injured worker's treatment history included MRI, medications, physical therapy, epidural steroid injections, acupuncture treatment, chiropractic sessions and a urine drug screen. The injured worker had undergone an MRI of the cervical spine on 01/04/2013 that revealed a 3 mm disc bulge or disc osteophyte complex at C5-6 which, together with prominent ligamentum flavum buckling, results in moderate to severe central spinal stenosis with slight indentation of the ventral surface of the cord; a 2 mm disc bulge with mild ligamentum flavum buckling at C4-5 results in mild central spinal stenosis; mild right neural foraminal narrowing at C4-5; a 2 mm bulge at T1-2; 2 mm anterior disc protrusion at T3-4 that was incompletely evaluated and, if clinically indicated, a dedicated MRI of the thoracic spine may be obtained for further evaluation; mild bilateral facet spondylosis at C4-5; mild, left worse than right, facet spondylosis at C5-6; mild right uncovertebral spondylosis at C4-5; disc desiccation from C2-3 through C5-6 as well as T1-2; mild disc height loss at C2-3, C4-5 and C5-6. The injured worker had undergone an epidural injection at bilaterally at C4-5 on 09/05/2013 with 20% to 50% relief. The injured worker was evaluated on 06/18/2014, and it was documented the injured worker complained of neck pain and low back pain. The pain radiated down bilateral upper extremities. The pain radiated bilaterally to the shoulders. The neck pain was associated with bilateral occipital headaches. The pain was aggravated by activity, flexion/extension, repetitive head motion and rotation. It was rated as 8/10 in intensity with medications, and without medications it was 8/10. In the documentation, the provider noted the injured worker was status post transforaminal epidural steroid injection bilaterally at L4-S1 that

took place on 03/18/2014 that provided 50% to 80% overall improvement of pain relief. There was functional improvement in the following areas: mood, sitting, walking and improved mobility. Physical examination of the cervical spine revealed spinal vertebral tenderness was noted in the cervical spine, C4-7. There was tenderness noted upon palpation at the trapezius muscles bilaterally. There was occipital tenderness upon palpation bilaterally. The range of motion of the cervical spine was moderate due to pain. The pain was significantly increased with flexion, extension and rotation. Motor exam showed decreased strength in the extensor muscles and the flexor muscles bilaterally. Physical examination of the lumbar spine revealed spasm was noted. Tenderness was noted upon palpation of the spinal vertebral area at L4-S1 levels. The range of motion of the lumbar spine was mildly limited secondary to pain. Sensory exam showed decreased sensitivity to touch along L4-S1 dermatome in both lower extremities. Motor examination showed decreased strength in the bilateral lower extremities which was moderate. Straight leg raise with the injured worker in the seated position was positive bilaterally at 50%. The injured worker was given a Toradol injection with B12, right gluteal, and reported good pain relief. Diagnoses included cervical degeneration, cervical facet arthropathy, cervical radiculopathy, lumbar radiculopathy, and chronic pain syndrome. Medications included alprazolam, aspirin, atenolol, glipizide, Lisinopril and metformin. The Request for Authorization was not submitted for this review. However the rationale for the trigger point injection was for to alleviate symptomatology somewhat for the injured worker alleviate.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective trigger point injection to the upper trapezius muscles bilaterally consisting of 2cc Celestone 10mg/5ml and 6cc lidocaine 10 mg/30ml: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger Point Injections & Criteria for the use of Trigger point Injections Page(s): page(s) 122.

Decision rationale: California (MTUS) Chronic Pain Medical Guidelines recommends trigger point injections 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 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) for fibromyalgia syndrome, trigger point injections have not been proven effective. The guidelines also states trigger point injections may be used 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. The guidelines only recommend the use of trigger pint injections for myofascial pain syndrome and not radiculopathy. The provider indicated the injured worker stated she has had epidural injections in the past; however, the long-term outcome measurements or functional improvement goals were not provided. Given the above, the request for retrospective trigger point injection to the upper trapezius muscles bilaterally consisting of 2cc Celestone 10mg/5ml and 6cc lidocaine 10mg/30ml is not medically necessary.