

Case Number:	CM14-0167266		
Date Assigned:	10/14/2014	Date of Injury:	02/07/1997
Decision Date:	11/17/2014	UR Denial Date:	10/02/2014
Priority:	Standard	Application Received:	10/10/2014

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 Internal 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:

The injured worker (IW) is a 63-year-old woman with a date of injury of February 7, 1997. She strained her back and right arm putting up signs at the shopping mall. She was diagnosed with cervical region pain and lumbar back pain. Previous treatments included activity modification, medications, and aquatic therapy. MRI of the cervical spine revealed no abnormalities of the C2-3 level. Relatively mild circumferential bulge of the C5-6 disc is more prominent towards the left. There is a relatively mild bulge of the C2-3 disc. The IW has received multiple steroid injections with fluoroscopy in the cervical spine and lumbar region of her back, multiple trigger point injections, physical therapy and home exercise program, all of which would provide temporary relief in most cases. The IW has completed 12 therapy visits March 8, 2013 followed by a 3-month membership to allow access and therapist supervision of underwater treadmill. Another 24 visits was approved and completed December 9, 2013. The most recent cervical trigger point injection (TPI) was December 16, 2013. This did not result in a decrease of medications or evidence of improved function. The IW was re-evaluated September 12, 2014. Chief complaint was bilateral neck pain and bilateral low back pain. She has 6 weekly migraines a month. Noted that cervical TPI gave the IW 50% relief in the past lasting longer than 2 months. Physical examination of the cervical spine revealed myofascial pain with tenderness and positive twitch sign. The IW has trigger points in the cervical as well as lumbar region. There has been no change in activities of daily living reported. There is no documentation of pain level pre and post TPI. Her medications include Nortriptyline, Gabapentin, and NSAIDs, and Relpax, Ambien, Lidocaine 5% ointment, Nabumetone, Lansoprazole, Tramadol, Methocarbamol, Calcium, and Vitamin D. The IW denies any adverse side effects. No aberrant drug related behaviors were noted. It was noted on August 25, 2014 that the injured worker's medication provide more than

50% pain relief and allowed for increase exercise capacity. She has been encouraged to look into gyms with aquatic therapy components.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical trigger point injections with ultrasound guidance: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger Point Injections Page(s): 122. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Pain; Trigger Point Injections

Decision rationale: The Chronic Pain Medical Treatment Guidelines provide the criteria for trigger point injections. They include documentation of circumscribed trigger points with evidence of the twitch response; symptoms have persisted for greater than three months; medical management such as stretching physical therapy non-steroidal anti-inflammatory's and most relaxants fail to control pain; not more than three - four injections per session; 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; frequency should not be an interval less than two months in trigger point injections with any substance other than local anesthetic with or without steroid not recommended. In this case, the medical record shows the patient had 50% relief in the past lasting longer than two months. Physical examination of the cervical spine showed myofascial pain with tenderness and positive twitch sign. The patient received trigger point injections in the cervical region. However, there is been no reduction in medication to treat the symptoms, and there has been no change in activities of daily living. The patient's pain level was not documented pre-and post-trigger point injections. Consequently, there is no documentation of functional improvement nor or the pre-and post-trigger point injection pain levels. Based on the clinical information in the medical record and the peer reviewed, evidence-based guidelines, the cervical trigger point injections with ultrasound guidance are not medically necessary and appropriate.