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| Case Number: | CM14-0168502 | | |
| Date Assigned: | 10/16/2014 | Date of Injury: | 11/10/2000 |
| Decision Date: | 11/19/2014 | UR Denial Date: | 09/23/2014 |
| Priority: | Standard | Application Received: | 10/13/2014 |

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 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 49-year-old woman who sustained a work-related injury on March 21, 2003. Subsequently, he developed with the chronic neck and back pain. According to a progress report dated on February 14 2014, the patient was reported to have chronic neck pain radiating to right upper extremity, low back pain radiating to both lower extremities and upper extremity pain in the right side. The patient pain severity was rated 6-7/10 with medications and 8-9/10 without medications. The patient was treated with cervical epidural steroid injection at the level of C4 C6 on December 13, 2013 with the 50-80% overall improvement. The patient was treated with the opioid pain medications with some pain and functional improvement. The patient physical examination demonstrated cervical and lumbar tenderness with reduced range of motion, lumbar tenderness with reduced range of motion and positive straight leg raise on the right side. The physical diagnostic testing demonstrated right L5 nerve irritation. MRI of the lumbar spine performed on 2010 and demonstrated the lumbar canal stenosis with foraminal narrowing. MRI of cervical spine demonstrated the cervical stenosis with a mild left foraminal narrowing. The patient was diagnosed with cervical radiculopathy, lumbar disc disease, lumbar facet arthropathy, right knee pain, and status post right knee surgery. The provider requested authorization for trigger point injection of the cervical spine.

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: 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 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 and trigger points over the cervical spine. There is no documentation of failure of oral medications or physical therapy in this case. Therefore, the request for Trigger point injection for the cervical spine is not medically necessary.