

<b>Case Number:</b>	CM14-0180658		
<b>Date Assigned:</b>	11/05/2014	<b>Date of Injury:</b>	03/01/2010
<b>Decision Date:</b>	12/11/2014	<b>UR Denial Date:</b>	10/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/30/2014

### 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 60-year-old woman who sustained a work related injury on March 1, 2010. Subsequently, she developed chronic shoulder, neck, and elbow pain. MRI of the left shoulder dated March 21, 2014 showed tearing of anterior labrum and tearing of posterosuperior labrum. There was low grade partial thickness articular sided tear at leading edge of supraspinatus tendon at footprint. No high grade rotator cuff tear. There was mild posterior subluxation of humeral head with respect to glenoid. There was mild acromioclavicular joint degenerative changes. MRI of the cervical spine dated May 29, 2014 showed annular tear with a 2 mm posterior central disc protrusion at C4-5, which indents the anterior thecal sac but does not result in significant spinal stenosis. Disc bulge with a 2-3 mm posterior central disc protrusion at C6-7, which indents the anterior thecal sac but does not result in significant spinal stenosis. 2-3 mm disc bulge at C5-6, which indents the anterior thecal sac but does not result in significant spinal stenosis. Mild bilateral neuroforaminal narrowing at C6-7 on the basis of uncovertebral spondylosis. Straightening and mild reversal of normal cervical spine curvature, which may be positional or related to muscle spasm. Disc desiccation C2-3 through C6-7 with mild disc height loss at C5-6. According to a progress report dated August 7, 2014, the patient complained of persistent neck pain, stiffness, and soreness, and also left shoulder pain and weakness. She stated that her pain level is at 7/10. She stated the medication provides her good relief of her symptoms, normally 40-50%. She noted that the left C4-5 transforaminal epidural steroid injection under fluoroscopy performed on April 18, 2014 did help improve her function throughout the day. Examination of the cervical spine revealed a limited range of motion and increased pain at extreme of flexion and extension. There was minimal diffuse tenderness to palpation at the right and left trapezius muscles with some palpable spasm. Sensation and motor function of the upper extremities were grossly intact bilaterally. Range of motion of the left shoulder was limited with increased pain at

extremes of range of motion and showed some atrophy of the rotator cuff muscles and the deltoid muscle of the left shoulder. The patient was diagnosed with cervical degenerative disc disease with radiculopathy and stenosis, left shoulder impingement, and left wrist pain. The provider requested authorization for Trigger Point Injection Cervical Spine and Ultrasound Guidance for Injection.

### **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 Criteria for Use Page(s): 122.

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

**Decision rationale:** According to California Medical Treatment Utilization Schedule (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, non-steroidal anti-inflammatory drugs (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 Trigger point injection cervical spine is not medically necessary.

**Ultrasound Guidance for 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:** 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 Trigger point injection cervical spine with Ultrasound Guidance for Injection is not medically necessary.