

Case Number:	CM13-0011241		
Date Assigned:	03/26/2014	Date of Injury:	05/12/2009
Decision Date:	01/07/2015	UR Denial Date:	08/06/2013
Priority:	Standard	Application Received:	08/14/2013

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 Family 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 is a 46-year-old female who experienced an industrial injury 05/12/09. There was a pain management progress report dated 07/26/13 noted the worker complained of neck and back pain. Regarding her back pain, she continued to have deep axial back pain in the lumbar area that radiated down to her buttocks and posterior lower limbs. She reported her neck pain had increased muscle tightness and spasms in her head, cervical and parascapular muscles. She noted the Tizanidine 4 mg which she takes one capsule three times per day helped but not completely and she did fine with trigger point injections. Her current medications included Neurontin 300 mg four times per day, Norco 10 mg-325, one tablet four times per day as needed. She reported she was able to decrease the usage of Norco from 5 times a day to 4 times a day. She also takes Topamax 25 mg one tablet twice per day, and neuropathic pain and headaches. She noted the medications help decrease her pain severity by greater than 55 percent as well as increase her functional level with no adverse effects from the pain medications. Cervical MRI showed kyphosis most likely secondary to muscle spasms and there were no other significant findings. The mechanism of injury and body part(s) affected were not noted except in the psychiatric evaluation report dated 04/18/13 which noted the worker reported the mechanism of injury as she had "picked up that mixer thing, the bowl. I picked up the bowl that day, and I started the next day hurting. When I picked up that mixing bowl, I heard some popping, something in my body. I guess it was my shoulders because they hurt so bad the next day." Upon the physician's physical examination on 07/26/13, noted she was in moderate distress, but there were no significant findings. The lumbar spine noted pain over the intervertebral spaces (discs) on palpation. Palpable twitch positive trigger points are noted in the lumbar paraspinal muscles. Her gait appeared antalgic, anterior lumbar flexion caused pain, there was pain noted with lumbar extension, and she did have decreased deep tendon reflex on the left. Diagnoses were cervical

degenerative disc disease, unspecified neuralgia neuritis and radiculitis, cervical radiculopathy, lumbosacral radiculopathy, Fibromyalgia/myositis, degenerative disc disease lumbar, joint pain shoulder. Recommended treatment was trigger point injections of the cervical paraspinal and parascapular muscles since this was reported as helping with her muscle tightness and pain in the past. The patient reported she had fallen in her bathroom after her shower on 04/26/13, she could not get up and her husband had to call 911. She was treated in the emergency department with "shots" in her shoulder, x-rays, and a prescription for Diazepam 5 mg. She has continued to follow up with the same treating physician for similar cervical and lumbar subjective complaints with her pain rating from 7-10 on 1/10 scale. The objective findings remained similar at each visit and she continued to receive trigger point injections. There was mention on the 06/27/13 report, that the physician was concerned about the weakness of her lower leg which could indicate a more severe case in which she may need surgery to prevent loss of function of her leg. Treatment request is for cervical and periscapular trigger point injections and was denied mainly due to the various guidelines (i.e.: ACOEM, ODG, etc.) indicating the injections have a limited lasting value.

IMR ISSUES, DECISIONS AND RATIONALES

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

CERVICAL AND PERISCAPULAR TRIGGER POINT INJECTIONS: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 221, 26, 40, 54, 122. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic), cervical and periscapular trigger point injections, per ODG website

Decision rationale: Trigger point injections are not recommended in the absence of myofascial pain syndrome. The effectiveness of trigger point injection is uncertain, in part due to the difficulty of demonstrating advantages of active medication over injection of saline. Needling alone may be responsible for some of the therapeutic response. The only indication with some positive data is myofascial pain; may be appropriate when myofascial trigger points are present on examination. Trigger point injections are not recommended when there are radicular signs. The request is not medically necessary as there is no diagnosis of myofascial pain syndrome and patient does have cervical radiculopathy diagnosis.