

Case Number:	CM14-0202502		
Date Assigned:	12/15/2014	Date of Injury:	03/06/2012
Decision Date:	01/30/2015	UR Denial Date:	11/26/2014
Priority:	Standard	Application Received:	12/03/2014

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:

This is a male worker with a date of injury of August 6, 2012. The mechanism of injury is unknown. Diagnoses included cervical disc disease, cervical radiculopathy, and right shoulder internal derangement and cervicogenic headaches. On October 15, 2014, the injured worker complained of cervical spine and right shoulder pain. He rated his pain as a 9-10 on a 1-10 pain scale. Physical examination revealed tenderness and spasm over the paravertebral musculature and left trapezius muscle. Tenderness to palpation was present over the sternocleidomastoid with increased pain on right rotation with spasm and guarding noted. Palpation over the cervical paraspinal musculature reproduced headaches. Also, he was noted to have multiple trigger points in the mid trapezius region. He underwent a second C5-6 and C6-7 transfacet epidural steroid injections on September 19, 2014. He stated he was better for three weeks with 80% less pain and full range of motion of the cervical spine. He reported decreased radicular symptoms and decreased numbness and tingling with 80% improvement for three weeks. Medication was also listed as a treatment. A request was made for left paravertebral trigger point injection under ultrasound guidance. On December 1, 2014, utilization review denied the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left paravertebral trigger point injection under ultrasound guidance: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection.

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

Decision rationale: Trigger point injections are recommended for myofascial pain syndromes but produce limited lasting value and are not indicated for radicular pain. It is recommended to be given with a local anesthetic such as Bupivacaine but not with a corticosteroid. Trigger points are described as discrete focal tenderness in a palpable taut band of skeletal muscle which produces a local twitch in response to stimulus to the band. About 33-50% of the general population is reported to have such trigger points. Myofascial pain syndrome is a regional painful muscle condition with a direct relationship between the associated painful region and a specific trigger point. These injections for pain are not recommended for typical neck or back pain. The chronic pain section lists the following criteria for use of trigger point injections for patients. 1-documentation of circumscribed trigger points should be made and evidence on palpation of twitching response and pain should be noted; 2-symptoms should last more than 3 weeks, 3-other modalities such as exercise, NSAID's, and muscle relaxants should have been attempted and failed, 4-radiculopathy should not be present, 5-repeat injections should not be given unless there is a greater than 50% pain relief documented and functional improvement noted, 6-frequency of injections should not be more often than every 2 months and injection should not be given with any other substance other than a local anesthetic. In the above patient we do not see any documentation by the MD of evidence of a twitching response on palpation of the tender area and we have no information stating that the patient has received such modalities as NSAID's, muscle relaxants, or exercise modalities to treat the patient's pain. Therefore, the UR was justified in its denial of the procedure and the request for Left paravertebral trigger point injection under ultrasound guidance is not medically necessary and appropriate.