

<b>Case Number:</b>	CM15-0136275		
<b>Date Assigned:</b>	07/24/2015	<b>Date of Injury:</b>	08/08/2013
<b>Decision Date:</b>	08/21/2015	<b>UR Denial Date:</b>	07/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/15/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: Texas, Florida, California  
 Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

### 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 43 year old male, who sustained an industrial injury on 8/08/2013. He reported being hit in the head causing a fall with loss of consciousness. Diagnoses include post-concussion syndrome, closed head injury, multiple contusions, post traumatic migraine headaches with nausea, upper back/neck strain, and bilateral shoulder jamming injury with forward fall, possible labral tear and instability. Treatments to date include medication therapy, chiropractic therapy, and cortisone injection. Currently, he complained of ongoing pain in the neck with radiation and headaches. The provider documented previous medial branch blocks were successful in relieving symptoms for some hours and were indicative for diagnostic success. Prior trigger point injections were noted to be successful in relieving pain. On 7/9/15, the physical examination documented tenderness on the top of his head and occiput, cervical muscles and bilateral upper back T1 region. There was a positive apprehension test. The plan of care included a request for bilateral C3 and C4 medial branch blocks and for myofascial triggers point injection to the left upper back.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Bilateral C3 and C4 medial branch blocks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back under Medical Branch Blocks, Diagnostic.

**Decision rationale:** This claimant was injured about two years ago when hit in the head. This caused a fall with loss of consciousness. Diagnoses include post-concussion syndrome, closed head injury, multiple contusions, post traumatic migraine headaches with nausea, upper back/neck strain, and bilateral shoulder jamming injury with forward fall, possible labral tear and instability. Treatments to date included medication therapy, chiropractic therapy, and cortisone injection with unknown functional outcomes. There is still ongoing neck pain. Previous medial branch blocks were said to be successful in relieving symptoms and prior trigger point injections were noted to be successful in relieving pain, however there is no mention of objective functional improvements out of the injections. As of July 2015 there is still pain at the head and neck. The current California web-based MTUS collection was reviewed in addressing this request. The guidelines are silent in regards to this request. Therefore, in accordance with state regulation, other evidence-based or mainstream peer-reviewed guidelines will be examined. The ODG notes: Criteria for the use of diagnostic blocks for facet mediated pain: 1. One set of diagnostic medial branch blocks is required with a response of 70%. The pain response should be approximately 2 hours for Lidocaine. 2. Limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally. 3. There is documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks. 4. No more than 2 joint levels are injected in one session (see above for medial branch block levels). 5. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated. (Resnick, 2005). 6. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. The surgical plans in this claimant are not clear. Moreover, objective improvement out of past injections is not known. Finally, if the initial medial branch blocks were successful [ $>$  or  $=$  70% pain relief], then the next step is not to repeat the block, but move on to more semi permanent ablation interventions. The request is appropriately not medically necessary.

**Myofascial trigger point injection to left upper back:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. MTUS (Effective July 18, 2009) Page(s): 47 of 127.

**Decision rationale:** As shared previously, this claimant was injured about two years ago when was hit in the head causing a fall with loss of consciousness. Diagnoses include post-concussion syndrome, closed head injury, multiple contusions, post traumatic migraine headaches with nausea, upper back/neck strain, and bilateral shoulder jamming injury with forward fall, possible labral tear and instability. Treatments to date include medication therapy, chiropractic therapy, and cortisone injection with unknown functional outcomes. There is still ongoing neck pain. Prior trigger point injections were noted to be successful in relieving pain, however there is no mention of objective functional improvements out of the injections. As of July 2015, there is still pain at the head and neck. The MTUS notes 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. Classic triggering with circumscribed myofascial twitch response was not demonstrated. The patient has had them before, without documented long term, objective, functional benefit. The request is appropriately not medically necessary.