

<b>Case Number:</b>	CM15-0148665		
<b>Date Assigned:</b>	08/11/2015	<b>Date of Injury:</b>	01/27/2014
<b>Decision Date:</b>	09/09/2015	<b>UR Denial Date:</b>	07/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/31/2015

### 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: New Jersey, Alabama, California  
 Certification(s)/Specialty: Neurology, Neuromuscular 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 48-year-old female who sustained an industrial injury on January 27, 2014 resulting in headaches, right shoulder, and neck pain. She was diagnosed with right shoulder rotator cuff tear, right shoulder impingement, and acromioclavicular joint arthrosis. Documented treatment has included physical therapy, trigger point injections and occipital nerve blocks, which helped with headaches, right shoulder subacromial injection with temporary relief of shoulder pain and neck spasms, and medication. The injured worker continues to complain of right shoulder pain, neck spasms and headaches. The treating physician's plan of care includes 8 additional trigger point injections and 4 additional occipital nerve blocks. She is presently working.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Trigger point injections times 8: 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 and regarding shoulder pain, Invasive techniques have limited proven value. If pain with elevation significantly limits activities, a subacromial injection of local anesthetic and a corticosteroid preparation may be indicated after conservative therapy (i.e., strengthening exercises and nonsteroidal anti-inflammatory drugs) for two to three weeks. The evidence supporting such an approach is not overwhelming. The total number of injections should be limited to three per episode, allowing for assessment of benefit between injections. Furthermore and 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." In this case, there is no clear evidence of cervical spine myofascial pain. The patient's recent physical examination did not reveal evidence upon palpation of a twitch response as well as referred pain. In addition, the patient previously had trigger point injections with only 3 weeks of relief of symptoms and no evidence of functional improvement (guidelines require at least 6 weeks of relief of symptoms after the injection with evidence of functional improvement). Therefore, the request for Trigger point injections times 8 is not medically necessary.

**Occipital nerve blocks times 4:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 11th Edition (Web), 2014, Neck and Upper Back (Acute & Chronic) (updated 06/25/15), Greater occipital nerve block, diagnostic; ODG, Head (updated 01/21/14), Greater occipital nerve block (GONB).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Greater occipital nerve block, therapeutic. <http://www.worklossdatainstitute.verioiponly.com/odgtwc/neck.htm#Greateroccipitalnerveblocktherapeutic>.

**Decision rationale:** According to ODG guidelines, occipital nerve block, therapeutic "Under study for treatment of occipital neuralgia and cervicogenic headaches. There is little evidence that the block provides sustained relief, and if employed, is best used with concomitant therapy modulations. (Biondi, 2005) Current reports of success are limited to small, non-controlled case series. Although short-term improvement has been noted in 50-90% of patients, many studies only report immediate post injection results with no follow-up period. In addition, there is no gold-standard methodology for injection delivery, nor has the timing or frequency of delivery of injections been researched. (Haldeman, 2001) (Inan, 2001) (Vincent, 1998) Limited duration of effect of local anesthetics appears to be one factor that limits treatment and there is little research as to the effect of the addition of corticosteroid to the injectate." In this case, the patient underwent occipital nerve block, which afforded her approximately 3 weeks or relief of symptoms. There is no evidence of functional improvement and sustained relief. In addition, there is no controlled studies supporting the use of occipital nerve block for the treatment of the patient's pain. Therefore, the request for Occipital nerve blocks times 4 is not medically necessary.