

Case Number:	CM15-0180389		
Date Assigned:	09/22/2015	Date of Injury:	08/10/1994
Decision Date:	11/02/2015	UR Denial Date:	09/01/2015
Priority:	Standard	Application Received:	09/14/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 58 year old female who sustained an industrial injury on 08-10-1994. Diagnoses include cervical radiculopathy, C5-6 herniated nucleus pulpous, lumbar radiculopathy, L4-5, L5-S1 disc bulges, chronic myofascial dysfunction and diabetes (non-industrial). A physician progress note dated 08-06-2015 documents the injured worker has complaints of neck pain that radiates to her bilateral arms and forearms in the C6 distribution. She has low back pain that radiates to her bilateral posterolateral thighs. Medications provide good relief, 30 to 40%, without side effects and allow her to perform ADL's. She has left greater than right lower back pain and spasms. She had received trigger point injections about 2 years ago with good relief. Spurling's is positive and sensation is decreased in her bilateral arms and forearms in the C6 distribution. She has a decreased grip. Straight leg raise is positive bilaterally at 60 degrees. Sensation is decreased in her posterior thighs, and there are Triggers bilaterally at L5. Treatment to date has included diagnostic studies, medications, trigger point injections, and a home exercise program. Physician notes from 04-09-2015 to 07-13-2015 show little change in pain and-or treatments. The treatment plans includes refilling Neurontin, Percodan, and Zanaflex, continuation of her home exercise program, and continue with the orthopedist and reevaluate in 2 months. On 09-01-2015 the Utilization Review non-certified, the requested treatments of 2 trigger point injection under ultrasound.

IMR ISSUES, DECISIONS AND RATIONALES

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

2 trigger point injection under ultrasound: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Trigger point injections.

Decision rationale: The patient presents with neck pain that radiates to bilateral arms and forearms in C6 distribution, and low back pain that radiates to bilateral posterolateral thighs. The request is for 2-trigger point injection under ultrasound. Physical examination to the cervical spine on 05/14/15 revealed decreased sensation in bilateral arms and forearms in C6 distribution. Examination to the lumbar spine revealed decreased sensation in posterior thighs. Per 08/06/15 progress report, patient's diagnosis includes cervical radiculopathy, C5-6 HNP, lumbar radiculopathy, L4-5, L5-S1 disc bulge, chronic myofascial dysfunction, and diabetes (non-industrial). Patient's medications, per 06/04/15 include Neurontin, Percocet, and Zanaflex. Patient is permanent and stationary. MTUS Chronic Pain Medical Treatment Guidelines, page 122, Trigger Point Injection section has the following: "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)" The treater has not specifically addressed this request. Review of the medical records provided indicates that the patient has had previous trigger point injections. The patient continues with neck pain radiating to the bilateral upper extremities and low back pain that radiates into the bilateral posterolateral thighs; patient's diagnosis include cervical and lumbar radiculopathy. MTUS guidelines indicate that radiculopathy must not be present in order for trigger point injections to be considered medically appropriate. Furthermore, there is no mention of twitch response or referred pain on physical examination. This patient does not meet the criteria for trigger point injections. Therefore, the request is not medically necessary.