

<b>Case Number:</b>	CM15-0202107		
<b>Date Assigned:</b>	10/19/2015	<b>Date of Injury:</b>	05/04/2015
<b>Decision Date:</b>	11/30/2015	<b>UR Denial Date:</b>	09/30/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/14/2015

### 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: Colorado

Certification(s)/Specialty: Family Practice

### 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 34 year old male, who sustained an industrial injury on 5-4-15. The documentation on 9-8-15 noted that the injured worker has complaints of head and face pain rated 7 out of 10 and it is throbbing and aching with pain in his ears as well. Cervical pain is rated 7 to 8 out of 10 that is aching tight and worse with movement. Right shoulder pain is 5 to 6 out of 10 and is sharp and worse with overhead use and reaching. The injured worker has a shuffling gait and moves about gingerly and with stiffness. There is tenderness in the left, mid and right cervical and cervicothoracic regions with palpable trigger points. There is pain in the right shoulder superior deltoid region. Spurling's test is negative and Hawkins and Neer's are positive in the right shoulder. The diagnoses have included sprain of neck; sprains and strains of unspecified site of shoulder and upper arm and blunt trauma right face and head. Treatment plan included to start chiropractic treatment 2 times a week for 3 weeks to the cervical spine and right shoulder; schedule ENT due to continued head, face and ear throbbing, aching pain; neurologist schedules due to continued head, face and ear throbbing and recommend trigger point injection to the cervical spine. The original utilization review (9-30-15) non-certified the request for trigger point injections, cervical spine. Several documents within the submitted medical records are difficult to decipher.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Trigger Point injections, cervical spine: Upheld**

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

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

**Decision rationale:** Per the guidelines, trigger point injections are only recommended for myofascial pain syndrome, which is specifically defined as a "regional painful muscle condition with a direct relationship between a specific trigger point and its associated pain region." While trigger point injections, in some cases, have been used to maintain function, they are generally not of lasting value. A trigger point is defined as a localized area of tenderness and a taut band of skeletal muscle that can be palpated, resulting in a twitch in response to the palpation. Up to 50% of the adult population may have trigger points, but trigger point injections are only recommended when patient has myofascial pain syndrome that relates a trigger point to an area of referred pain. If patient has myofascial pain syndrome with unresolved trigger points, then trigger point injection with an anesthetic may be recommended. Addition of a steroid to the anesthetic in the injection is not generally recommended. Trigger point injections have not been proven effective and would therefore not be recommended in typical back or neck pain or in fibromyalgia. (Graff-Radford, 2004) (Nelemans-Cochrane, 2002) (Goldenberg, 2004) Trigger point injections would only be recommended in chronic low back or neck pain with myofascial pain syndrome if all criteria for use are met: Trigger points must be documented with evidence of twitch response and referred pain upon exam. Symptoms must be present for > 3 months. Medical therapies including muscle relaxers, non-steroidal anti-inflammatory drugs, and physical therapy have failed to improve symptoms. There should be no Radiculopathy, by exam, imaging or other testing. No more than 3-4 injections are to be done per session. Repeat injections are not indicated unless pain relief > 50% and evidence of function improvement after initial injection is documented. No injections at interval of less than 2 months. Use of anything in the trigger point injection other than local anesthetic with or without steroid is not recommended. (Colorado, 2002) (BlueCross BlueShield, 2004) Per the records supplied, the patient does not have a diagnosis of myofascial pain syndrome. There is no documented twitch response or referred pain for patient's trigger point(s). The records are unclear as to whether or not patient has tried and failed physical therapy. The request for trigger point injection does not specify substance to be used in the injection. Without a diagnosis of myofascial pain syndrome and referred pain and without evidence of failure of physical therapy, and without information on the substance to be used in the injection, the patient does not meet criteria for trigger point injection, and the request for trigger point injection of the cervical spine is not medically necessary.