

Case Number:	CM15-0045065		
Date Assigned:	03/17/2015	Date of Injury:	12/20/2013
Decision Date:	04/23/2015	UR Denial Date:	02/09/2015
Priority:	Standard	Application Received:	03/10/2015

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, Michigan, 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 was a 58-year-old female, who sustained an industrial injury, December 20, 2013. The injured worker was struck by a patient in the left side of the jaw. The injured worker immediately felt pain in the neck that shot down the bilateral arms. The injured worker previously received the following treatments cervical neck surgery, physical therapy, x-rays, CT scan, EMG/NCV (electromyography/nerve conduction velocity studies), Norco, MS-Contin, Gabapentin, Lyrica, Topamax, Elavil, Pamelor, Cymbalta, Soma, Robaxin, Flexeril, Baclofen, Tizanidine, Lidoderm, Voltaren gel, Motrin, Tylenol, Aleve, Zanaflex and acupuncture. The injured worker was diagnosed with chronic severe intractable neck pain requiring pain management, status post decompression and fusion occiput to C2 as well as C4-C5 and C5-C6 decompression and fusion secondary to motorcycle accident, insomnia associated with chronic pain and myofascial pain trigger point to the cervical trapezius region. According to progress note of January 8, 2015, the injured workers chief complaint was severe pain and spasms of the neck region. The injured worker also was having intermittent headaches, nausea and vomiting associated with the pain. The injured worker rated the pain at a constant 8 out of 10; 0 being no pain and 10 being the worse pain. The pain was aggravated with activity, repetitive use, pulling, lifting, reaching over the head and pushing. The pain was partially better with rest and medication. The physical exam noted diffuse tenderness over the cervical spine and paraspinal region. There was tenderness to palpation over the bilateral trapezius, splenius and levator scapula. There was trigger point with tightness over the cervical, splenius and trapezius/levator

scapular region. The treatment plan included trigger point injections times two for myofascial pain over the cervical and trapezius region.

IMR ISSUES, DECISIONS AND RATIONALES

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

2 Trigger Point Injections to the Cervical Spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger Point Injection. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Trigger Point Injection.

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

Decision rationale: 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. There is no clear evidence of cervical spine myofascial pain. There is no documentation from the patient file that he have 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). There is no documentation that the trigger point injections are performed as an adjacent therapy as recommended by ODG guidelines.

Therefore, the request for 2 Trigger Point Injections to the Cervical Spine is not medically necessary.