

<b>Case Number:</b>	CM15-0045925		
<b>Date Assigned:</b>	03/18/2015	<b>Date of Injury:</b>	02/13/2001
<b>Decision Date:</b>	04/23/2015	<b>UR Denial Date:</b>	02/25/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/11/2015

### 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: Massachusetts

Certification(s)/Specialty: Anesthesiology, Pain Management

### 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 54 year old female, who sustained an industrial injury on February 13, 2001. She reported chronic low back pain and cervical spine pain with associated bilateral upper extremity radiculopathy. The injured worker was diagnosed as having cervical degenerative joint disease. Treatment to date has included radiographic imaging, diagnostic studies, surgical intervention, chiropractic care, home use of a TENS unit, trigger point injections of the cervical spine, medications and work restrictions. Currently, the injured worker complains of chronic neck and low back pain with associated upper extremity radiculopathies. The injured worker reported an industrial injury in 2001, resulting in the above noted pain. She was treated conservatively, surgically and with trigger point injections without complete resolution of the pain. She reported a temporary 60% relief of pain with trigger point injections and reported temporary benefit with chiropractic care. Evaluation on December 24, 2014, revealed continued pain. Medications were renewed and additional trigger point injections were recommended.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Trigger point injection for the neck (7 site): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Trigger Point Injections Page(s): 120.

**Decision rationale:** According to the MTUS, trigger point injections are 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 trigger point injections have not been proven effective. (Goldenberg, 2004). Criteria for the use of Trigger point injections: 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. (Colorado, 2002) (BlueCross BlueShield, 2004) According to the documents available for review, the injured worker does have a trigger point of discreet focal tenderness located in a palpable top band of skeletal muscle, which produces a local twitch in response to stimulus to the band. The request for 7 TPI is in contrast to the MTUS guidelines of not more than 4 injections per session. Therefore at this time the requirements for treatment have not been met and medical necessity has not been established.