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| Case Number: | CM15-0088121 | | |
| Date Assigned: | 05/12/2015 | Date of Injury: | 03/27/1993 |
| Decision Date: | 06/22/2015 | UR Denial Date: | 04/14/2015 |
| Priority: | Standard | Application Received: | 05/07/2015 |

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 67 year old male with an industrial injury dated 05/14/1991. His diagnoses included traumatic brain injury, cervical herniated nucleus pulposus with radiculopathy, and lumbar herniated nucleus pulposus with radiculopathy, myofascial pain syndrome, lumbar sprain/strain, essential tremor, myoclonus, brain injury, depressive disorder and insomnia. He presents on 03/31/2015 with complaints of cervical and lumbar radiculopathies, severe intractable myofascial pain syndrome and migraines (with benefits from recent trigger point injections, 6 weeks prior). Prior treatments included trigger point injections, pool therapy, medications and cane. Physical exam revealed finger to nose test normal and slow unsteady gait using a cane. Sensory (pin prick) was impaired diffusely to the face, torso and upper and lower extremities. Treatment plan included a request for trigger point injections, pool therapy and gym membership. Other treatment included medications and CT of head due to frequent falls.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ten (10) bilateral trigger point injections, every month for cervical and lumbar spine, rhomboid, periscapular and mid and lower spine regions with Lidocaine 1% and Marcaine 0.5% (10 cc's total): 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." According to the guidelines, the injections should not be performed at an interval less than 2 months and there should be documentation of at least 50% of pain relief for at least 6 weeks. There is no documentation from the patient's file that he has Medical management therapies such as ongoing stretching exercises, physical therapy, NSAIDs and muscle relaxants have failed to control pain. In addition, the presence of radiculopathy is not excluded: the patient has subjective complaints of radiculopathy. Therefore, the request for 10 bilateral trigger point injections, every month for cervical and lumbar spine, rhomboid, periscapular and mid and lower spine regions with Lidocaine 1% and Marcaine 0.5% (10 cc's total) is not medically necessary.