

Case Number:	CM14-0183597		
Date Assigned:	11/10/2014	Date of Injury:	03/01/2010
Decision Date:	12/16/2014	UR Denial Date:	10/16/2014
Priority:	Standard	Application Received:	11/04/2014

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. The expert reviewer is Board Certified in Anesthesiologist, Pain Medicine and is licensed to practice in Florida. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 61-year-old female who reported an injury on 03/01/2010 due to an unspecified mechanism of injury. The injured worker complained of consistent neck pain that radiates to the left arm. Current medication included aspirin, atenolol, Cocet, and isosorbide. The diagnoses included shoulder acromioclavicular joint arthritis, shoulder arthralgia, elbow arthralgia, cervicgia, cervical radiculitis, bicipital tenosynovitis, thoracic spine arthralgia, impingement/bursitis of the shoulder, shoulder sprain/strain of the rotator cuff, upper extremity sprain/strain, sprain/strain of unspecified site of the elbow, cervical myofascial sprain/strain, thoracic sprain/strain, and abrasion/friction on burn or infection. The MRI of the cervical spine dated 05/29/2014 revealed anterior tear of the 2 mm posterior central disc protrusion at the C4-5, which indents the anterior thecal sac, but does not result in significant spinal stenosis; disc protrusion with a 2 to 3 mm posterior anterior disc protrusion at C6-7, which indents the anterior thecal sac but does not result in significant spinal stenosis. Also reported mild bilateral neural foraminal narrowing at the C6-7 on the basis of uncovertebral spondylosis as directed above; straightening and mild reversal of the normal cervical spine curvature, which may be positional or related to muscle spasms; and disc desiccation at the C2-3 through the C6-7, with mild disc height loss at C5-6. Other treatments included medication, epidural steroid injection, and physical therapy. The objective findings dated 11/03/2014 of the cervical spine reveals tenderness to the trapezius musculature. Range of motion revealed stiffness. There was a negative Spurling's test with sensation intact to the upper extremities. Treatment plan included trigger point injection at the cervical spine. The Request for Authorization dated 11/10/2014 was within the documentation. The rationale for the trigger point injection was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Trigger point injection cervical spine QTY: 1:00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of Trigger point injections Page(s): 122.

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

Decision rationale: The request for Trigger point injection cervical spine QTY: 1:00: is not medically necessary. The California MTUS guidelines recommend lumbar trigger point injections only for myofascial pain syndrome as indicated below, with limited lasting value, and it is not recommended for radicular pain. 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 (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. The documentation lack the objective findings that included a twitch response. Additionally, the documentation was not evident of failed conservative care and radiculopathy is not present. As such, the request is not medically necessary.

Ultrasound guidance for injection QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of Trigger point injections Page(s): 122.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.