

<b>Case Number:</b>	CM15-0114141		
<b>Date Assigned:</b>	06/22/2015	<b>Date of Injury:</b>	03/11/2014
<b>Decision Date:</b>	07/28/2015	<b>UR Denial Date:</b>	05/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/12/2015

### 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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 41 year old female who sustained an industrial injury on 3/11/14 from repetitive keyboarding resulting in ongoing discomfort at the inner and outer elbow that started going into her upper arm and neck pain. Initially there was confusion as to whether this was industrial or non-industrial related. She was treated with medications; posterior elbow injections which did not help; chiropractic treatments. She had electromyography/ nerve conduction study which was normal; MRI (10/10/14) showing lateral epicondylitis. She currently complains of pain in the bilateral aspect of the cervical spine with pain and numbness radiating into the bilateral upper extremities. Her pain level is 9/10. On physical exam there was tenderness from C3/4 to C6/7 on the right with limited cervical and right upper extremity range of motion; tenderness over the medial and lateral epicondyle on the right. There was a positive Tinel's at the right wrist and elbow. She has sleep difficulties. Medication is Aleve. Diagnoses include cervicalgia; cervical disc bulging, degenerative disc disease, radiculopathy, facet joint syndrome; limb pain; lateral epicondylitis. Treatments to date include medication; H-wave; rest; aquatic therapy which was helpful; home exercise program; physical therapy; transcutaneous electrical nerve stimulator unit; acupuncture (per 2/23/15 note); chiropractic adjustments. Diagnostics include MRI of the cervical spine (10/1/14) showing paracentral disc protrusion; MRI of the right upper extremity (10/1/14) showing lateral epicondylitis. In the progress note dated 5/13/15 the treating provider's plan of care included a request for ultrasound guided bilateral trapezius trigger point injections. Utilization Review evaluated a request for bilateral ultrasound guided trigger point injections to the cervical spine on 5/21/15.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Bilateral ultrasound guided trigger point injection to the cervical spine:** 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 based on Non-MTUS Citation Official disability guidelines neck chapter, trigger points injection.

**Decision rationale:** The patient was injured on 03/11/14 and presents with pain in her cervical spine which radiates into the bilateral upper extremities. The request is for BILATERAL ULTRASOUND GUIDED TRIGGER POINT INJECTION TO THE CERVICAL SPINE. The RFA is dated 05/13/15 and the 04/24/15 report states that the patient is "off work x 3 weeks from March 27, 2015 to April 17, 2015. No use of right arm." The report with the request is not provided and there is no documentation of any prior trigger point injection the patient may have had to the cervical spine. The MTUS Guidelines, on page 122, state that "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." ODG guidelines, neck chapter, trigger points injection section, states the following: "Not recommended in the absence of myofascial pain syndrome. See the pain chapter for criteria for the use of trigger point injections. The effectiveness of trigger point injection is uncertain, in part due to the difficulty of demonstrating advantages of active medication over injection of saline. Needling alone may be responsible for some of the therapeutic response. The only indication with some positive data is myofascial pain; maybe appropriate when myofascial trigger points are present on examination. Trigger point injections are not recommended when there are radicular signs, but they may be used for cervicgia." The patient has a positive Tinel's on the right wrist and elbow, small right paracentral disc protrusions with mild thecal sac narrowing at the C5-6 and C6-7 levels (10/01/14 MRI), tenderness over the paraspinal musculature from C3/4 to C6/7 on the right, limited cervical and right upper extremity range of motion, and tenderness over the medial and lateral epicondyle on the right. She is diagnosed with cervicgia, cervical disc bulging, degenerative disc disease, radiculopathy, facet joint syndrome, limb pain, and lateral epicondylitis. Treatments to date includes medication, H-wave, rest, aquatic therapy, home exercise program,

physical therapy, transcutaneous electrical nerve stimulator unit, acupuncture, and chiropractic adjustments. Review of the reports provided does not indicate if the patient had any prior trigger point injections. There are no documented circumscribed trigger points with evidence upon palpation of a twitch response, as required by MTUS guidelines. The request does not meet guideline criteria. Furthermore, the patient presents with radiculopathy which is not indicated by MTUS guidelines. The request does not meet guideline criteria. The requested trigger point injection to the cervical spine IS NOT medically necessary.