

Case Number:	CM15-0177458		
Date Assigned:	09/18/2015	Date of Injury:	12/20/2011
Decision Date:	10/20/2015	UR Denial Date:	08/28/2015
Priority:	Standard	Application Received:	09/09/2015

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: North Carolina

Certification(s)/Specialty: Family Practice

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 39 year old female with an industrial injury dated 12-20-2011. A review of the medical records indicates that the injured worker is undergoing treatment for cervical discogenic disease at C5-C6 and C6-C7 with no evidence of facet disease. Medical records indicate ongoing neck and bilateral shoulder complaints. Treatment consisted of radiographic imaging, urine drug screens, prescribed medications, injection therapy, thermal ablation to her neck and periodic follow up visits. In an agreed medical examination report dated 04-27-2015, the injured worker reported primarily cervical spine pain with significant radiating left upper extremity symptoms. Left shoulder exam (4-27-2015) revealed no evidence of impingement, instability, no pain with range of motion and no evidence of tenderness. According to the progress note dated 06-15-2015, the injured worker reported neck pain rated a 3 out of 10 and bilateral shoulder pain rated a 5 out of 10. Objective findings (06-15-2015) revealed full range of motion in bilateral shoulder, decrease cervical range of motion, flexion and extension with pain in her neck going into left shoulder, rotation 30 degrees to right with pain in neck going down her left arm, rotate to left 45 degrees with very little pain, neck tilt 30 degrees to the right and 15 degrees to the left with pain in her neck going down left arm. Mild spasm of trapezius muscle was also noted on exam. On 06-15-2015, the injured worker's work status was regular duty. The treating physician prescribed services for trigger point injection, left shoulder, now under review. The original utilization review (08-28-2015) denied the request for trigger point Injection, left shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Trigger Point Injection, Left Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines: Criteria for use of Trigger Point Injections.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Trigger point injections.

Decision rationale: The California chronic pain medical treatment guidelines section on trigger point injections states: Trigger point injections 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) 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) The provided clinical documentation fails to show circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain. Therefore criteria have not been met and the request is not medically necessary.