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| Case Number: | CM14-0216441 | | |
| Date Assigned: | 01/06/2015 | Date of Injury: | 06/20/1993 |
| Decision Date: | 11/25/2015 | UR Denial Date: | 12/16/2014 |
| Priority: | Standard | Application Received: | 12/26/2014 |

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. 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: Washington, California

Certification(s)/Specialty: Preventive Medicine, Occupational 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 female with an industrial injury date of 06-20-1992. Medical record review indicates she is being treated for cervical spondylosis without myelopathy and interstitial myositis. Prior treatments included massage therapy, right C3 medial branch radiofrequency neurotomy, chiropractic treatment, home exercise program and medications. In a provider progress note dated 11-19-2014, the injured worker complained of continued chronic cervical pain and shoulder pain. The pain was rated as 4/10. Current medications included Naproxen and Lidoderm patch and pain gel. Physical exam noted normal gait and posture, tenderness to cervical paraspinal and C3, C4 and C5 facets, right upper extremity motor weakness (+3/5) of deltoids, triceps and wrist extensors, decreased sensation right C6 and right C7 and normal reflex exam of the upper and lower extremities. On 12-16-2014 the request for 1 cervical myofascial trigger point injections was non-certified by utilization review.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 cervical myofascial trigger point injections: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, and Acupuncture Treatment 2007, and Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck & Upper Back Chapter.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Initial Care, and Chronic Pain Medical Treatment 2009, Section(s): Trigger point injections.

Decision rationale: Trigger point injections are injections of medications, usually anesthetics and/or steroids although saline, glucose and other agents may also be used, into areas of muscles where pressure on these areas causes focal pain with or without radiation or referred pain. MTUS criteria for use of this treatment modality includes pain over 3 months duration, medical management has failed to control the pain, there are documented trigger points on exam as evidenced by palpation that triggers local pain, referred pain and a twitch response and that there is no documented radiculopathy. The MTUS criteria for repeat trigger point injections require a greater than 50% improvement in pain relief and maintenance of this relief for 6 weeks after the prior injection. ACOEM guidelines note that there is no proven benefit from trigger point injections in treating acute neck and upper back symptoms. Review of this patient's available records reveals that other than local tenderness none of the physical findings that would define a trigger point were documented for this patient. Since the diagnosis of trigger point is not validated by an exam consistent with this diagnosis, medical necessity for this procedure has not been demonstrated. Therefore, the request is not medically necessary.