Case Number:	CM14-0119638		
Date Assigned:	08/06/2014	**Date of Injury:**	05/05/2014
Decision Date:	11/18/2014	**UR Denial Date:**	07/10/2014
Priority:	Standard	**Application Received:**	07/30/2014

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 Occupational Medicine and is licensed to practice in Montana. 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 housekeeper with a date of injury 5/5/14 when she tripped and fell. She has complaint of neck and right shoulder pain. Examination has shown tenderness with palpation of the right cervical, trapezius and shoulder areas with a normal sensory and motor examination. She has painful right shoulder motion with positive impingement signs. X-rays showed disc space narrowing at C5-6 and acromioclavicular joint arthritis of the right shoulder. Her diagnosis is right shoulder rotator cuff strain and early adhesive capsulitis, cervical strain, right cervical radiculitis and cervicalgia. She has been treated with physical therapy, ibuprofen, Flexeril and Norco. The primary treating physician has requested intra-articular cortisone injection of the right shoulder under ultrasound/echo and trigger point cortisone injection of paracervical musculature.

IMR ISSUES, DECISIONS AND RATIONALES

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

Intra-articular cortisone injection of right shoulder under ultrasound/echo.: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints,Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Steroid injection

Decision rationale: The MTUS does state that corticosteroid injections into the subacromial bursa are an option for impingement syndrome. 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. The ODG guidelines recommended steroid injections of the shoulder as indicated below, up to three injections. Steroid injections compared to physical therapy seem to have better initial but worse long-term outcomes. Rotator cuff: For rotator cuff disease, corticosteroid injections may be superior to physical therapy interventions for short-term results, and a maximum of three are recommended. If pain with elevation is significantly limiting activities, a subacromial injection of local anesthetic and a corticosteroid preparation may be indicated after conservative therapy (i.e., strengthening exercises and NSAIDs) for two to three weeks, but the evidence is not yet overwhelming, and the total number of injections should be limited to no more than three.Impingement syndrome: In a large randomized trial on the management of subacromial impingement syndrome by physical therapists there was no significant difference in the score on the shoulder pain and disability index at three months in participants who received a combination of injection and exercise compared with those who received exercise therapy alone, but significantly earlier improvements in pain and functional disability at one and six weeks were seen in the group given corticosteroid injection. Both physical therapy and corticosteroid injections significantly improve symptoms in patients with shoulder impingement syndrome (approximately 50% improvement in Shoulder Pain and Disability Index scores maintained through 1 year), but physical therapy may be more efficient.Criteria for Steroid injections:- Diagnosis of adhesive capsulitis, impingement syndrome, or rotator cuff problems, except for post-traumatic impingement of the shoulder;- Not controlled adequately by recommended conservative treatments (physical therapy and exercise, NSAIDs or acetaminophen), after at least 3 months;- Pain interferes with functional activities (eg, pain with elevation is significantly limiting work);- Intended for short-term control of symptoms to resume conservative medical management;- Generally performed without fluoroscopic or ultrasound guidance;- Only one injection should be scheduled to start, rather than a series of three;- A second injection is not recommended if the first has resulted in complete resolution of symptoms, or if there has been no response;- With several weeks of temporary, partial resolution of symptoms, and then worsening pain and function, a repeat steroid injection may be an option; The number of injections should be limited to three. The ODG guidelines note that glucocorticoid injection for shoulder pain has traditionally been performed guided by anatomical landmarks alone, and that is still recommended. With the advent of readily available imaging tools such as ultrasound, image-guided injections have increasingly become more routine. While there is some evidence that the use of imaging improves accuracy, there is no current evidence that it improves patient-relevant outcomes. Although ultrasound guidance may improve the accuracy of injection to the putative site of pathology in the shoulder, it is not clear that this improves its efficacy to justify the significant added cost. A recent meta-analysis confirms this. While there was a statistically significant difference in pain and abduction between landmark-guided and US-guided steroid injections for adults with shoulder pathology, these differences were small and do not represent clinically useful effects. In this case the utilization review did certify the intra-articular cortisone injection of right shoulder without ultrasound/echo guidance. The request for the intra-articular cortisone injection of right shoulder under ultrasound/echo is not medically necessary.

Trigger point cortisone injections paracervical musculature.: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints,Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174-175.

Decision rationale: The MTUS, in the ACOEM guidelines, states that invasive techniques such as injection of trigger points have no proven benefit in treating acute neck and upper back symptoms. However, many pain physicians believe that diagnostic and/or therapeutic injectionsmay help patient's presenting in the transitional phase between acute and chronic pain. ODG Guidelines note that trigger point injections (TPIs) are not recommended in the absence of myofascial pain syndrome. 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; may be 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 cervicalgia.ODG criteria for TPIs 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) No more than 3-4 injections per session; (6) No repeat injections unless a greater than 50% pain relief with reduced medication use 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)TPIs with any substance (e.g., saline or glucose) other than local anesthetic with or without steroid are not recommended; (9) There should be evidence of continued ongoing conservative treatment including home exercise and stretching. Use as a sole treatment is not recommended; (10) If pain persists after 2 to 3 injections the treatment plan should be reexamined as this may indicate a lack of appropriate diagnosis, a lack of success with this procedure, or a lack of incorporation of other more conservative treatment modalities for myofascial pain. It should be remembered that trigger point injections are considered an adjunct, not a primary treatment.In this case, although there is a diagnosis of cervical radiculopathy, the primary treating physician has described clinical findings of trigger points in the cervical/trapezius area. The request for trigger point injections is not specific as to the number of injections to be provided per session. The utilization review did modify and certify the request for 3 injections. As such, the request for trigger point cortisone injections paracervical musculature is not medically necessary.