

<b>Case Number:</b>	CM14-0048299		
<b>Date Assigned:</b>	07/02/2014	<b>Date of Injury:</b>	06/16/1997
<b>Decision Date:</b>	09/22/2014	<b>UR Denial Date:</b>	03/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/16/2014

### 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 Preventative Medicine, has a subspecialty in Occupational Medicine and is licensed to practice in Iowa. 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:

This patient is a 52 year old employee with date of injury of 6/16/1997. Medical records indicate the patient is undergoing treatment for right shoulder pain; lumbar facet syndrome; failed back surgery syndrome and myofascial pain. On 3/26/2013 the patient underwent a revision thoracic laminectomy; removal of battery leads on the dorsal epidural space in thoracic spine; removal of IPG battery in gluteal area; fluoroscopy for assessment of anatomic level and interpretation and revision closure of thoracic and left gluteal incisions. Subjective complaints include significant back and buttock pain. Her right lower extremity radicular symptoms are worse than the left. Her worst pain comes from axial back pain. She continues to have headaches, neck pain and abdominal/pelvic pain. Her pain is described as pressure, aching, sore and gnawing, shock, stabbing, sharp, burning pins and needles and throbbing-shock-like. She describes muscle cramps, weakness and aches along with joint stiffness. Her pain is rated as a 9/10. Objective findings include a positive straight leg raise exam (left) produces concordant back and leg pain; numbness in left L5 distribution. She has palpatory tenderness over lower lumbar facet joints. Her right shoulder has lateral and posterior tenderness to palpation; decreased right internal range of motion; pain with shoulder abduction; left sacroiliac joint tenderness to palpation and she is positive for lumbar facet loading. Treatment has consisted of Vitamin D, Cetirizine HCl, Klonopin, Celexa, Wellbutrin, Augmentin, Arthrotec PO, Vicodin PO, Lidocaine, Norco, Ibuprofen, Methylsulfonylmethane and Aldactone. Her physician states that that patient's thoracic paraspinous muscle pain has failed exercise therapy, heat, massage, chiropractic care and massage. The utilization review determination was rendered on 3/13/2014 recommending non-certification of Series of 3 Injections to the right Shoulder Joint.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Series of 3 Injections to the right Shoulder Joint: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines : Steroid Shoulder Injections.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-214. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder.

**Decision rationale:** ACOEM Table 9-6 states that there is limited research based evidence in the use of shoulder injections. ODG provides additional guidance based on symptoms and diagnosis. ODG 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 (e.g., 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 treating physician has not detailed shoulder pain subjective and objective findings to indicate such pathology as rotator cuff, adhesive capsulitis, AC joint osteoarthritis, or glenohumeral osteoarthritis. Additionally, the treating physician has not detailed a trial and failure of conservative treatment. As such, the request for Series of 3 Injections to the right Shoulder Joint is not medically necessary.

### **1 Trigger Point Injections to the Thoracic Paraspinous Muscle: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Trigger Point Injections.

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

**Decision rationale:** MTUS states 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. The treating physician has not detailed the outcome of previous trigger point injections. In addition, the treating physician did not detail a trial and failure of conservative treatment. As such, the request for 1 Trigger Point Injections to the Thoracic Paraspinal Muscle is not medically necessary.