

Case Number:	CM15-0213140		
Date Assigned:	11/02/2015	Date of Injury:	02/19/2002
Decision Date:	12/22/2015	UR Denial Date:	09/30/2015
Priority:	Standard	Application Received:	10/29/2015

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: Internal 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 61 year old female, who sustained an industrial injury on February 19, 2002, incurring left shoulder injuries. She was diagnosed with a left rotator cuff tear and biceps tendon tear. Treatment included physical therapy, pain medications, muscle relaxants, proton pump inhibitor, and trigger point injections to the left shoulder with activity restrictions. She underwent shoulder surgery in 2005, and in 2006. Currently, the injured worker complained of persistent left shoulder pain with restricted range of motion. She complained of gastrointestinal upset secondary to medication usage. She was diagnosed with dyspepsia, left shoulder effusion and shoulder sprain. Upon examination, the injured worker was noted to have increased tenderness of the left shoulder and limited mobility of the left shoulder. The treatment plan that was requested for authorization included a prescription for Omeprazole-delayed release 20 mg #30, and a request for two left shoulder trigger point injections under ultrasound guidance. On September 29, 2015, a request for a prescription for Omeprazole and a request for trigger point injections were denied by utilization review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole (Delayed release) 20mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic): NSAIDs, GI Symptoms & Cardiovascular risk: Proton Pump Inhibitor.

Decision rationale: Based on ODG guidelines, the following is used to determine if the patient is at risk for gastrointestinal events: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). A history of ulcer complications is the most important predictor of future ulcer complications associated with NSAID use. Proton pump inhibitors are recommended for patients at risk for gastrointestinal events. In this case, the patient is younger than 65 years old, does not have a history of peptic ulcer or GI bleeding and is not on high dose or multiple NSAIDs. Therefore, based on ODG guidelines, the request for Omeprazole (Delayed release) 20mg #30 is not medically necessary.

Left shoulder trigger point injections under ultrasound guidance times 2: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute & Chronic): trigger point injections, Pain (Chronic): trigger point injections.

Decision rationale: Based on ODG guidelines, trigger point injections are recommended for myofascial pain syndrome as indicated below, with limited lasting value. The advantage appears to be in enabling patients to undergo remedial exercise therapy more quickly. The primary goal of trigger point therapy is the short-term relief of pain and tightness of the involved muscles in order to facilitate participation in an active rehabilitation program and restoration of functional capacity. TPIs are generally considered an adjunct rather than a primary form of treatment and should not be offered as either a primary or a sole treatment modality. (Scott, 2005) See Myofascial pain. A recent systematic review came to the conclusion that the efficacy of TPIs was no more certain than it was a decade ago, and that there continued to be no clear cut evidence of either benefit or ineffectiveness. There is no evidence-based or consensus research to suggest an optimal technique. The mechanism of inactivation of the trigger point remains unknown. Many consider dry needling as effective as a TPI. It has been suggested that the main effect is placebo. (Cummings, 2001) There are no studies that compare "stretching" treatment alone or "no treatment" to TPIs. Most current studies have evaluated the use of a TPI as a stand-alone treatment. (Scott, 2008) (Staal, 2008) Indications: The main indication is to inactivate the trigger point in order to reduce pain and restore function. This may enable physical therapy. The injection is also used as a diagnostic tool. (Scott, 2008) Whiplash and chronic head, neck, shoulder and back pain: The evidence for TPIs when used as a sole treatment for patients with whiplash syndrome or chronic head, neck, shoulder or back pain (regardless of injectate) is inconclusive and the treatment does not appear to be more effective than treatments such as laser

or ultrasound. These injections are not recommended for typical chronic low back or neck pain, nor are they recommended for radicular pain. Fibromyalgia: There is no evidence to support trigger point injections for this condition using randomized controlled trials. Uncontrolled trials suggest that dry needling or soft-tissue injections with lidocaine are equally effective.

(Goldenberg, 2004) Cervicogenic headaches: The effectiveness is unknown. (Scott, 2005)

Osteoarthritis: There is one randomized controlled trial that indicates that the addition of TPIs to intra-articular injections improves pain and function over and above the latter injection alone.

Criteria for the use of TPIs (Trigger point injections): TPIs with a local anesthetic may be recommended for the treatment of 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, the patient has shown more than 50% improvement in pain with trigger point injections, but twitch response was not documented on examination. Therefore, based on ODG guidelines and the evidence in this case, the request for left shoulder trigger point injections under ultrasound guidance times 2 is not medically necessary.