

Case Number:	CM15-0213891		
Date Assigned:	11/03/2015	Date of Injury:	08/25/2014
Decision Date:	12/18/2015	UR Denial Date:	10/09/2015
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: New York, Tennessee
 Certification(s)/Specialty: Emergency 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 46 year old male who sustained an industrial injury August 25, 2014, described as a right shoulder contusion. Past treatment included prescriptions for Motrin and Norco and placed in an arm sling. Diagnoses are right rotator cuff capsule tear; tenosynovitis, right bicipital; epicondylitis, right lateral; pain in joint right upper arm; cervical sprain strain; thoracic sprain strain. According to a primary treating physician's progress report dated October 2, 2015, the injured worker presented with cervical spine pain, rated 8 out of 10, with reduced range of motion, right elbow pain, rated 9 out of 10, with reduced range of motion and right shoulder pain, rated 8 out of 10, with pain radiating down the right arm. He also reported gastroesophageal reflux symptoms without hemoptysis-gastrointestinal bleed symptoms. He uses a TENS (transcutaneous electrical nerve stimulation) unit two times a day with effective relief of muscle spasms and pain in the elbow, neck and back. Current medication included Fenoprofen and Gabapentin. Omeprazole started at this visit for mild gastritis. Objective findings included; cervical spine-full range of motion with spasm to back; right shoulder-elbow-tenderness to palpation and light touch and spasm radiating from shoulder to wrist; back-tenderness to palpation with moderate pain radiating to the sacroiliac joints; abdomen is soft and non-tender to palpation with normal bowel sounds. At issue, is the request for authorization for 4 pairs of TENS patches and unknown ultrasound guided trigger point injections. According to utilization review dated October 9, 2015, the requests for (4) pairs of TENS patches and Unknown ultrasound guided trigger point injections were non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

4 pairs of TENS patches: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: TENS units are not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, including reductions in medication use, for neuropathic pain, phantom limb pain, spasticity, and multiple sclerosis. Several published evidence-based assessments of transcutaneous electrical nerve stimulation (TENS) have found that evidence is lacking concerning effectiveness. Functional restoration programs (FRPs) are designed to use a medically directed, interdisciplinary pain management approach geared specifically to patients with chronic disabling occupational musculoskeletal disorders. These programs emphasize the importance of function over the elimination of pain. FRPs incorporate components of exercise progression with disability management and psychosocial intervention. In this case there is no documentation that the patient is participating in a functional restoration program. In addition there is documentation that the use of the TENS unit is achieving analgesia. Conditions for TENS use have not been met. The request is not medically necessary.

Unknown ultrasound guided trigger point injections: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

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

Decision rationale: Trigger point injections are recommended only for myofascial pain syndrome as indicated below, with limited lasting value. 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. 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. Criteria for use of trigger point injections are as follows: 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. In this case there is no documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain. Criteria for trigger point injections have not been met. The request is not medically necessary.