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| Case Number: | CM15-0087338 | | |
| Date Assigned: | 07/16/2015 | Date of Injury: | 10/16/2005 |
| Decision Date: | 08/13/2015 | UR Denial Date: | 04/11/2015 |
| Priority: | Standard | Application Received: | 05/06/2015 |

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: North Carolina
 Certification(s)/Specialty: Family Practice

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 50-year-old female, who sustained an industrial injury on 10/16/2005. Diagnoses include left shoulder sprain status post arthroscopy x 2, cervical strain with left upper extremity radiculopathy and abdominal strains with multiple hernias. Treatment to date has included surgical intervention (left shoulder), as well as conservative measures including trigger point injections, massage and medications. Per the Narrative Primary Treating Physician's Emergency Visit dated 3/26/2015, the injured worker presented for an emergency drop in. She had tearing of the lateral colostomy site with increased pain and also a dental infection that had a tooth extraction but residual infection now to start antibiotics. She has increasing pain in the left shoulder with popping. She has left upper back, neck pain and spasms with radiation and weakness down the left arm. Physical examination revealed tenderness to the neck, upper back and trapezius and left medial scapular muscles with circumscribed areas and pain with drawl-twitch response with palpation. Left shoulder raise was 80 degrees and she had a weak left grip when compared to the right. The plan of care included the administration of injections, and authorization was requested for one intramuscular trigger point injection to the upper back, one left shoulder subacromial injection and one prescription of hydrocodone/acetaminophen 10/325mg #40.

IMR ISSUES, DECISIONS AND RATIONALES

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

Intramuscular and trigger point injection to upper back: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger point injections, Criteria for the use of Trigger point injections.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines trigger point injection Page(s): 122.

Decision rationale: The California chronic pain medical treatment guidelines section on trigger point injections states: Trigger point injections: Recommended only for myofascial pain syndrome as indicated below, with limited lasting value, not recommended for radicular pain. 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. Not recommended for radicular pain. 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. These injections may occasionally be necessary to maintain function in those with myofascial problems when myofascial trigger points are present on examination. Not recommended for typical back pain or neck pain. (Graff-Radford, 2004) (Nelemans-Cochrane, 2002) For fibromyalgia syndrome, trigger point injections have not been proven effective. (Goldenberg, 2004) Criteria for the use of Trigger point injections: 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. (Colorado, 2002) (BlueCross BlueShield, 2004) The provided clinical documentation meets criteria as outlined above and the request is medically necessary.

Left shoulder subacromial injection: Overturned

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204.

Decision rationale: The ACOEM chapter on shoulder pain states: 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 requested service is a recommended treatment option per the ACOEM. The patient has ongoing shoulder pain. Therefore, the request is medically necessary.