

<b>Case Number:</b>	CM14-0181104		
<b>Date Assigned:</b>	11/05/2014	<b>Date of Injury:</b>	06/28/2010
<b>Decision Date:</b>	12/17/2014	<b>UR Denial Date:</b>	10/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/31/2014

### 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 California. 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:

Injured worker is a male with date of injury 6/28/2010. Per pain medicine visit note dated 10/15/2014, the injured worker complains of right scapula pain and diffuse neck pain associated with headaches. He reports diffuse neck pain status post suprascapular RF with 90% pain relief. He is back at work noting a pain posterior to the right shoulder rated 5/10. He had 80% relief after thoracic TPI, which is now coming back. Pain in the neck is returning from RF done 15 months ago, with headache. He reports using medications appropriately. He denies adverse side effects. He reports being stable functionally. There are no aberrant drug related behaviors. On examination the injured worker ambulates without a device. The injured worker's gait is normal. Examination of the thoracic spine paravertebral muscles reveal tight muscle band and trigger point (a twitch response was obtained along with radiating pain on palpation) is noted on both sides. The right shoulder has tenderness on palpation in the subdeltoid bursa. Diagnoses include 1) cervicgia 2) fasciitis not otherwise specified 3) pain in limb 4) pain in thoracic spine.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right Shoulder X-Ray:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder (updated 3/31/14) Radiography

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209.

**Decision rationale:** Per the MTUS Guidelines, the use of routine testing, including plain-film radiograph of the shoulder, and more specialized imaging studies are not recommended during the first month to six weeks of activity limitation due to shoulder symptoms, except when a red flag noted on history or examination raises suspicion of a serious shoulder condition or referred pain. Primary criteria for ordering imaging studies include 1) emergence of a red flag 2) physiologic evidence of tissue insult or neurovascular dysfunction 3) failure to progress in a strengthening program intended to avoid surgery 4) clarification of the anatomy prior to an invasive procedure. If limitations due to consistent symptoms have persisted for one month or more, imaging may be considered in cases when surgery is being considered for a specific anatomic defect or to further evaluate the possibility of potentially serious pathology such as a tumor. The requesting provider did not provide a rationale for requesting a shoulder x-ray. Medical necessity of this request has not been established within the recommendations of the MTUS Guidelines. The request for Right Shoulder X-Ray is determined to not be medically necessary.

**Thoracic TPI with US Guidance:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Trigger Point Injections Page(s): 122.

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

**Decision rationale:** The MTUS Guidelines recommend the use of trigger point injections for myofascial pain syndrome as indicated, with limited lasting value. It is 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. 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. Trigger point injections are not recommended for typical back pain or neck pain. For fibromyalgia syndrome, trigger point injections have not been proven effective. Trigger points have been identified on examination; however there is no complaint of discomfort or functional limitation noted in regards to thoracic trigger points. Medical necessity of this request has not been established within the recommendations of the MTUS Guidelines. The request for Thoracic TPI with US Guidance is determined to not be medically necessary.

**Right Shoulder Injection with US Guidance:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chapter 9 Shoulder Complaints Page(s): 48; 204,211.

**Decision rationale:** Per the MTUS Guidelines, injections of corticosteroids or local anesthetics or both should be reserved for patients who do not improve with more conservative therapies. Steroids can weaken tissues and predispose to reinjury. Local anesthetics can mask symptoms and inhibit long-term solutions to the patient's problem. If shoulder 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. Conservative care for impingement syndrome, including cortisone injections, can be carried out for at least three to six months before considering surgery. The requesting physician does not provide a rationale for the injection. The injured worker is not diagnosed with a rotator cuff injury or impingement syndrome. Medical necessity of this request has not been established within the recommendations of the MTUS Guidelines. The request for Right Shoulder Injection with US Guidance is determined to not be medically necessary.

#### **RFA Bilateral C3-C4 Right then Left: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Criteria for the use of facet joint radio frequency neurotomy

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck chapter, Facet Joint Radiofrequency Neurotomy section

**Decision rationale:** The MTUS Guidelines do not address the use of radiofrequency ablation of the cervical facet joints. The ODG reports that facet joint radiofrequency neurotomy is under study as there is conflicting evidence available as the efficacy of this procedure. Studies have not demonstrated improved function, however there may be pain reduction from the procedure. Criteria for use of cervical facet radiofrequency neurotomy includes 1) diagnosis of facet joint pain 2) adequate diagnostic blocks by documented improvement in VAS scores and improvement in function 3) no more than two joint levels are to be performed at one time 4) if different regions require neural blockade, they should be performed at intervals not sooner than one week and preferably two weeks for most blocks 5) there should be evidence of a formal plan of rehabilitation in addition to facet joint therapy 6) repeat neurotomies should not be required at an interval less than six months from the first procedure and duration of effects should be at least 12 weeks with 50% or greater relief. This request is for three levels, which is not supported by these guidelines. The claims administrator acknowledges that this radiofrequency ablation is

supported by the ODG for this injured worker. The claims administrator modified the request to provide the radiofrequency ablations during the same setting instead of two stages, which is not consistent with the recommendations of the ODG recommendations. The request for RFA Bilateral C3-C4 Right then Left is determined to be medically necessary.

**RETRO: Urine Drug Screen:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Drug Testing section, Opioids Criteria for Use Page(s): 43, 112.

**Decision rationale:** The use of urine drug screening is recommended by the MTUS Guidelines, in particular when patients are being prescribed opioid pain medications and there are concerns of abuse, addiction, or poor pain control. The injured worker has not been chronically prescribed opioid medications or other medications with concerns of abuse or addiction that may necessitate the use of urine drug screening. There is no assessment of aberrant drug behavior or concerns of abuse or poor pain control. Medical necessity of this request has not been established within the recommendations of the MTUS Guidelines. The request for RETRO: Urine Drug Screen is determined to not be medically necessary.

**RETRO: IR:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Low-Level Laser Therapy (LLLT) section Page(s): 57.

**Decision rationale:** Low level laser therapy is not recommended by the MTUS Guidelines. Given the equivocal or negative outcomes from a significant number of randomized clinical trials, it must be concluded that the body of evidence does not allow conclusions other than that the treatment of most pain syndromes with low level laser therapy provides at best the equivalent of a placebo effect. The request for RETRO: IR is determined to not be medically necessary.

**RETRO: E Stim:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 114-116.

**Decision rationale:** The use of TENS for chronic pain is not recommended by the MTUS Guidelines as a primary treatment modality, but a one-month home-based TENS trial may be

considered if used as an adjunct to a program of evidence-based functional restoration in certain conditions. A home based treatment trial of one month may be appropriate for neuropathic pain and CRPS II and for CRPS I. There is some evidence for use with neuropathic pain, including diabetic neuropathy and post-herpetic neuralgia. There is some evidence to support use with phantom limb pain. TENS may be a supplement to medical treatment in the management of spasticity in spinal cord injury. It may be useful in treating MS patients with pain and muscle spasm. The criteria for use of TENS include chronic intractable pain (for one of the conditions noted above) with documentation of pain of at least three months duration, evidence that other appropriate pain modalities have been tried (including medication) and failed, a one month trial period of the TENS unit should be documented as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used as well as outcomes in terms of pain relief and function, and a treatment plan including specific short and long term goals of treatment. The injured worker is reported to have been using a TENS unit. The rationale of this request has not been provided by the requesting physician. Medical necessity of this request has not been established within the recommendations of the MTUS Guidelines. The request for RETRO: E Stim is determined to not be medically necessary.