

Case Number:	CM15-0039625		
Date Assigned:	03/10/2015	Date of Injury:	12/23/2004
Decision Date:	04/20/2015	UR Denial Date:	02/10/2015
Priority:	Standard	Application Received:	03/03/2015

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 Jersey, Michigan, California
 Certification(s)/Specialty: Neurology, Neuromuscular 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 45 year old male who sustained a work related injury December 23, 2004. While stocking nail boxes, he developed hand numbness. He was diagnosed with bilateral wrist strain and received ibuprofen, neurology consultation, and a modified work schedule; physician noted a prior operation March, 1999. Past history includes cubital tunnel surgery bilateral, 2009 and left carpal tunnel surgery, 2005. According to a treating physician's progress notes, dated January 28, 2015, the injured worker presented for re-evaluation. He continues with residual of cubital tunnel syndrome bilaterally and mild left carpal tunnel syndrome. He now has a catching developing in the left middle finger and increasing catching to the point of locking in the adjacent ring finger. Assessment is documented as left non-dominant middle and rig STS (stenosing tenosynovitis) with locking. Diagnosis is documented as acquired trigger finger. Treatment plan included request for authorization for steroid injection to the proximal pulley sheath system sheath.

IMR ISSUES, DECISIONS AND RATIONALES

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

Trigger point injection series of 3 to left middle finger over 6 months: Upheld

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

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

Decision rationale: According to MTUS guidelines, trigger point injection is 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)"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". There is no documentation of failure of oral medications or physical therapy in this case. There is no documentation that the trigger point injections are performed as an adjunct therapy as recommended by ODG guidelines. In addition, the injection should not be repeated unless there is evidence of functional improvement. Therefore, the request for Trigger point injection series of 3 to left middle finger over 6 months is not medically necessary.