

Case Number:	CM15-0096183		
Date Assigned:	05/26/2015	Date of Injury:	12/17/2008
Decision Date:	06/24/2015	UR Denial Date:	05/06/2015
Priority:	Standard	Application Received:	05/19/2015

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, Alabama, 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 30 year old female, who sustained an industrial injury on 12/17/2008. On provider visit dated 02/18/2015 injured worker has reported increased pain to the left shoulder and left rhomboid. On examination of the left shoulder, impingement sign was positive and positive left trigger points, and decreased range of motion of left shoulder/cervical spine. The diagnoses have included myofascial pain syndrome, cervical spine strain, rotator cuff syndrome and status post left shoulder. Treatment to date has included medication, medication creams and trigger point injections. Ultrasound guided injection to cervical spine on 02/18/2015. The injured worker was noted as not working. The provider requested Lidoderm patches #60 with 2 refills and Trigger point injections x 4 to the left trap, rhomboid, paracervical muscles with Lidocaine 1% under ultrasound.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lidoderm patches #60 with 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch) Page(s): 56.

Decision rationale: According to MTUS guidelines, "Lidoderm is the brand name for a lidocaine patch produced by [REDACTED]. Topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin". In this case, there is no documentation that the patient developed neuropathic pain that did not respond to first line therapy and the need for Lidoderm patch is unclear. There is no documentation of efficacy of previous use of Lidoderm patch. Therefore, the prescription of Lidoderm patches #60, with 2 refills is not medically necessary.

Trigger point injections x 4 to the left trap, rhomboid, paracervical muscles with Lidocaine 1% under U/S: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), shoulder (acute and chronic).

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

Decision rationale: According to MTUS guidelines and regarding shoulder pain, 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. Furthermore and 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. In this case, there is no evidence of significant functional improvement from prior trigger point injections. In addition, there is no documentation that the trigger point injections are performed as part of ongoing management therapies as recommended by ODG guidelines. Therefore, the request for Trigger point injections x 4 to the left trap, rhomboid, paracervical muscles with Lidocaine 1% under U/S is not medically necessary.