MAXIMUS Federal Services

Case Number:	CM13-0038043		
Date Assigned:	12/18/2013	Date of Injury:	08/20/1996
Decision Date:	02/18/2014	UR Denial Date:	10/08/2013
Priority:	Standard	Application Received:	10/24/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation 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 physician 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:

The patient is a 55 year old female with complaints of chronic back, neck and hip pain resulting from an injury on 08/20/1996. The patient had an MRI of the left shoulder on 10/23/2013 with an impression of subacromial/subdeltoid bursitis and marked thinning of the supra and infraspinitus tendons without definite retracted full-thickness tear. There may be a partial thickness tear or a non-retracted full-thickness tear that could alternatively be considered, in setting of symptomatology referable to a rotator cuff tear, probably degeration of the anterior labrum, and intrascapular biceps tendon not well demonstrated. There may be intracapsular biceps tenosynovitis versus postoperative fixation, increased number of left axillary lymph nodes, with borderlines prominent and clinical correlation. The patient was seen on 11/06/2013 for her pain and was documented to have 3+ spasms to left and right trapezius, 3+ spasms to infraspinatus, 3+ spasms to serratus posterior superior, 3+ spasms to pyriformis left>right, 3+ spasms to left sacroiliac swelling/pain left>right. The patient was treated with trigger point injection of Depo Medrol with 1% lidocaine to the left and right anterior trapezius. The patient was seen on 11/19/2013 which noted the patient as having lots of relief from the injection but still had 3+ spasms to infraspinatus, 3+ spasms to serratus posterior superior, 3+ spasms to pyriformis left>right, 3+ spasms to left sacroiliac swelling/pain left>right . The patient was noted as having chronic neck and back pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

group of 3 sets of trigger point injections (left and right trapezii, infraspinatus, piriformis): Upheld

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

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

Decision rationale: The request for 3 sets of trigger point injections (left and right trapezii, infraspinatus, piriformis) is non-certified. The California MTUS guidelines recommend the use of trigger point injections when the patient meets all criteria. The patient was noted as having 3+ spasms to various areas of the back and neck region. However, the patient did not have evidence upon palpation of a twitch response as well as referred pain submitted for review. The guidelines recommend the use of trigger point injections for patients when medical management therapies such as ongoing stretching exercises, physical therapy, NSAIDs and muscle relaxants have failed to control pain. The patient was noted as being treated with a Fentanyl patch. However, the efficacy of conservative care was not submitted for review. The patient documentation submitted for review had objective findings that corroborated the diagnosis of radiculopathy on 05/29/2013. The trigger point injections are contraindicated in patients with radiculopathy. It is further noted the patient had an MRI which found underlying probable causation for the patient's symptomatology not correlating with the proposed treatment. Given the information submitted for review the request for 3 sets of trigger point injections (left and right trapezii, infraspinatus, piriformis) is non-certified.

set of massage therapy sessions: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 60.

Decision rationale: The request for massage therapy sessions is non-certified. The guidelines recommend massage therapy treatment should be an adjunct to other recommended treatment (e.g. exercise), and it should be limited to 4-6 visits in most cases. The documentation submitted for review did not address adjunct treatment. Furthermore, the request failed to specify the number of sessions. The guidelines recommend 4-6 sessions. This allows for re-evaluation of the patient's condition and efficacy of treatment. Given the information submitted for review the request for massage therapy sessions is non-certified.