

<b>Case Number:</b>	CM15-0210235		
<b>Date Assigned:</b>	10/29/2015	<b>Date of Injury:</b>	11/26/2003
<b>Decision Date:</b>	12/11/2015	<b>UR Denial Date:</b>	10/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/26/2015

### 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: Arizona, California

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 61 year old male who sustained an industrial injury on (11-26-03). The injured worker reported pain in the neck with radiation to bilateral shoulders, bilateral elbow and hand-wrist pain. A review of the medical records indicates that the injured worker is undergoing treatments for cervical degenerative disc disease, cervical spondylosis and myofascial sprain-strain, cubital tunnel syndrome, carpal tunnel syndrome and trigger finger. Medical records dated 9-25-15 indicate pain rated at 7 out of 10. Provider documentation dated 9-25-15 noted the work status as temporary totally disabled. Treatment has included radiographic studies, physical therapy, cervical magnetic resonance imaging, status post right carpal tunnel release (8-10-05), electrodiagnostic studies, Naprosyn since at least 2009, Hydrocodone since at least 2009, Norco, Diclofenac, Tizanidine, Gabapentin, Ultracet, injection therapy, and Psychiatric consultation. Objective findings dated 9-25-15 were notable for tenderness to the paravertebral musculature, trapezius, and tenderness to bilateral shoulder trapezius and subacromial with positive impingement test noted, sensation intact, right carpal tunnel with tenderness. The original utilization review (10-2-15) denied a request for Physical therapy 2 times a week for 4 weeks for the cervical spine and bilateral shoulder, Ultrasound guidance for needle placement related to bilateral shoulder injections and Magnetic resonance imaging (MRI) of the cervical spine without contrast.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy 2 times a week for 4 weeks for the cervical spine and bilateral shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Initial Care, and Shoulder Complaints 2004, Section(s): Initial Care, and Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

**Decision rationale:** According to the guidelines 8-10 sessions of therapy is recommended after which exercises can be performed at home. In this case, the injury is over 10 years old. The amount of therapy completed previously is unknown. The claimant was also requested to do home exercises indicating therapy for reeducation is more appropriate than a formal 4 week program. The request is not medically necessary.

**Ultrasound guidance for needle placement related to bilateral shoulder injections:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Shoulder Complaints 2004, Section(s): Summary. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter and pg 90.

**Decision rationale:** According to the ACOEM guidelines, trigger point injections are not recommended. Invasive techniques are of questionable merit. The treatments do not provide any long-term functional benefit or reduce the need for surgery. Therefore the request for lumbar trigger point injection is not medically necessary. According to the ODG guidelines trigger point injections are not recommended in the absence of myofascial pain: Criteria for the use of Trigger point injections: Trigger point injections (TPI) with a local anesthetic with or without steroid may be recommended for the treatment of chronic low back or neck pain with myofascial pain syndrome (MPS) 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 an indication (however, if a patient has MPS plus radiculopathy a TPI may be given to treat the MPS); (5) Not more than 3-4 injections per session; (6) No repeat injections unless a greater than 50% pain relief with reduced medication use 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; (9) There should be evidence of continued ongoing conservative treatment including home exercise and stretching. Use as a sole treatment is not recommended; (10) If pain persists after 2 to 3 injections the treatment plan should be re-examined as this may indicate an incorrect diagnosis, a lack of success with this procedure, or a lack of incorporation of other more conservative treatment modalities for myofascial pain. In this case, there was no specific indication of myofascial pain syndrome. Trigger injections provided only short term relief. They do not routinely require ultrasound guidance. The request is not medically necessary.

**Magnetic resonance imaging (MRI) of the cervical spine without contrast: 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), Neck & Upper Back - MRI.

**MAXIMUS guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Summary.

**Decision rationale:** According to the ACOEM guidelines, an MRI of the cervical spine is not recommended in the absence of any red flag symptoms. It is recommended to evaluate red-flag diagnoses including tumor, infection, fracture or acute neurological findings. It is recommended for nerve root compromise in preparation for surgery. There were no red flag symptoms. There was no plan for surgery. The claimant had a prior MRI in 2010 that indicated degenerative changes. The request for an MRI of the cervical spine is not medically necessary.