

Case Number:	CM15-0057203		
Date Assigned:	04/02/2015	Date of Injury:	08/07/2013
Decision Date:	06/04/2015	UR Denial Date:	03/18/2015
Priority:	Standard	Application Received:	03/25/2015

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, Michigan

Certification(s)/Specialty: Preventive Medicine, Occupational 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 27 year old female, who sustained an industrial injury on August 7, 2013. She reported feeling a pop in her left wrist that caused severe pain and right wrist and hand pain. The injured worker was diagnosed as having cervical spine myoligamentous sprain/strain syndrome, lumbar spine myoligamentous sprain/strain syndrome, and bilateral ankle sprain/strain and Achilles tendinitis. Treatment to date has included x-rays, MRIs, electrodiagnostic studies, work modifications, physical therapy to the neck and low back, acupuncture, and topical compound medication. On March 6, 2015, the injured worker complains of constant neck pain and stiffness that radiates to the back of the head and radiating pain, numbness and tingling down the arms to the fingers. She has constant bilateral wrist pain that radiates to the fingers of both hands, with numbness and tingling of the fingers. There is weakness with gripping or grasping objects. There is constant bilateral elbow pain that radiates down to the hands with numbness and tingling down to the bilateral fifth fingers. There is constant lower back pain that increases with sitting, standing, or walking over 10 minutes. There was no radiation of the pain, numbness or tingling in the lower extremities. There was bilateral ankle pain, worse on the back of the ankles. The physical exam revealed toe walking without difficulty, normal heel walking, decreased cervical range of motion with pain and normal range of motion of the shoulders, elbows, and forearms. There were normal deep tendon reflexes of the bilateral upper extremities and negative bilateral Finkelstein's. There was tenderness with myospasm of the cervical interspinous ligaments at cervical 2/cervical 3, cervical 4/cervical 5, and cervical 5/cervical 6; bilateral cervical spine paraspinous muscle spasm, bilateral cervical

spine posterior paraspinous muscle tenderness, and anterior scalene muscle tenderness and spasm, tenderness of the levator scapulae and parascapular superior/rhomboids. There was tenderness over the bilateral supraspinatus muscles on the upper shoulder with myospasm. The neck hyperextension test and Adson's maneuver were negative. There was decreased back range of motion with pain and normal bilateral hips range of motion, and bilateral ankle and feet range of motion, positive bilateral straight leg raise, negative bilateral Lasegue sign, intact bilateral sensory, normal motor power and reflexes of the bilateral lower extremities, tenderness of the lumbar interspinous ligaments at lumbar 4/lumbar 5 and lumbar 5/sacral 1, bilateral lumbosacral and sacroiliac ligament tenderness, myospasm of the lumbar paraspinal muscles, and tenderness of the bilateral sciatic notches. There were paravertebral trigger points with palpated tenderness and positive twitch response over the lumbar 3/lumbar 4, lumbar 4/lumbar 5, and lumbar 5/sacral 1. The treatment plan includes MRI of bilateral ankle, 2 in-office trigger/steroid injections to neck, and 2 in-office trigger/steroid injections to low back followed by 6 sessions of post injection physical therapy to neck and low back.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI (magnetic resonance imaging) Bilateral Ankle: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 373-374.

Decision rationale: Per the MTUS / ACOEM most cases presenting with true foot and ankle disorders, special studies are usually not needed until after a period of conservative care and observation. Most ankle and foot problems improve quickly once any red-flag issues are ruled out. Routine testing, i.e., laboratory tests, plain-film radiographs of the foot or ankle, and special imaging studies are not recommended during the first month of activity limitation, except when a red flag noted on history or examination raises suspicion of a dangerous foot or ankle condition or of referred pain. For patients with continued limitations of activity after four weeks of symptoms and unexplained physical findings such as effusion or localized pain, especially following exercise, imaging may be indicated to clarify the diagnosis and assist reconditioning. Stress fractures may have a benign appearance, but point tenderness over the bone is indicative of the diagnosis and a radiograph or a bone scan may be ordered. Imaging findings should be correlated with physical findings. Disorders of soft tissue (such as tendinitis, metatarsalgia, fasciitis, and neuroma) yield negative radiographs and do not warrant other studies, e.g., magnetic resonance imaging (MRI). Magnetic resonance imaging may be helpful to clarify a diagnosis such as osteochondritis dissecans in cases of delayed recovery. a review of the injured workers medical records did not reveal any red flags or suspicions of serious pathology and therefore the request for MRI (magnetic resonance imaging) Bilateral Ankle is not medically necessary.

2 (two) In-Office Trigger, Steroid Injections for Neck: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger point injections Page(s): 122. Decision based on Non-MTUS Citation Official Disability Guidelines: Pain.

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

Decision rationale: Per the MTUS, Trigger point injections are 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. 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. Per the MTUS, Criteria for the use of Trigger point injections: 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. A review of the injured workers medical records that are available to me do not show that she meets the above referenced criteria for trigger point injections, therefore the request for 2 (two) In-Office Trigger, Steroid Injections for Neck is not medically necessary.

2 (two) In-Office Trigger, Steroid Injections for Low Back: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger point injections Page(s): 122. Decision based on Non-MTUS Citation Official Disability Guidelines: Pain.

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

Decision rationale: Per the MTUS, Trigger point injections are 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. 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. Per the MTUS, Criteria for the use of Trigger point injections: 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. A review of the injured workers medical records that are available to me do not show that she meets the above referenced criteria for trigger point injections , therefore the request for 2 (two) In-Office Trigger, Steroid Injections for low back is not medically necessary.

Post Injection Physical Therapy for Neck and Low Back, 6 Sessions: 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 Physical medicine Page(s): 98-99.

Decision rationale: Per the MTUS, physical therapy is recommended following specific guidelines, allowing for fading of treatment frequency from up to 3 visits per week to 1 or less, plus active self directed home physical medicine. For myalgia and myositis unspecified the guidelines recommend 9-10 visits over 8 weeks. Neuralgia, neuritis and radiculitis unspecified 8-10 visits over 4 weeks. A review of the injured workers medical records that are available to me do not show that she meets the criteria for trigger point injections and therefore the associated request for Post Injection Physical Therapy for Neck and Low Back, 6 Sessions is not medically necessary.