

Case Number:	CM15-0082652		
Date Assigned:	05/05/2015	Date of Injury:	05/09/2014
Decision Date:	06/03/2015	UR Denial Date:	04/28/2015
Priority:	Standard	Application Received:	04/30/2015

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: California

Certification(s)/Specialty: Emergency 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 female, who sustained an industrial injury on March 9, 2014. She reported bilateral arm pain radiating into the elbows downward. The injured worker was diagnosed as having tenosynovitis hand and wrist, and lateral epicondylitis. Diagnostic studies to date have included an MRI of the right elbow. Treatment to date has included a surgical consultation and medications including antidepressant, anti-epilepsy, topical pain, non-steroidal anti-inflammatory, and muscle relaxer. The records refer to a prior course of physical therapy with myofascial release in both forearms, but do not provide specific dates or results. On April 15, 2015, the injured worker complains of bilateral forearm pain. The treating physician noted the pain was greater in the forearm's dorsal compartment, and it seemed to originate from the elbows into the extensor compartment. There was rare distally radiating pain with more vigorous activity. The injured worker reports the ability to tolerate 30-45 minutes of keyboarding before needing a 5-10 minute break. She reports lifting, grasping, and gripping more than 10 pounds with her bilateral upper extremities causes pain. The treating physician noted an MRI of the right elbow, which did not reveal lateral epicondylitis. The treating physician noted that the prior physical therapy was beneficial and improved her pain complaints. The physical exam revealed tenderness of the bilateral lateral epicondyle, resisted extension and supination with minimal pain, myofascial tenderness into the dorsal compartment of the bilateral forearm, negative Tinel's sign over the cubital and carpal tunnels, no gross motor deficits, and negative bilateral Finkelstein tests. The treatment plan includes a trial of trigger point injections to the bilateral

dorsal forearms and an additional 12 visits of physical therapy for myofascial release of the bilateral upper extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy x12 visits: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 264-265. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, Wrist and Hand (Acute & Chronic), Physical Therapy.

Decision rationale: The requested Physical therapy x12 visits is not medically necessary. American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 11, Forearm, Wrist and Hand Complaints, Physical Methods, Pages 264-265 and Official Disability Guidelines (ODG), Forearm, Wrist and Hand (Acute & Chronic), Physical Therapy, recommend continued physical therapy with documented objective evidence of derived functional improvement from completed physical therapy sessions as a transition to a dynamic home exercise program. The injured worker has bilateral forearm pain. The treating physician noted the pain was greater in the forearm's dorsal compartment, and it seemed to originate from the elbows into the extensor compartment. There was rare distally radiating pain with more vigorous activity. The treating physician has documented tenderness of the bilateral lateral epicondyle, resisted extension and supination with minimal pain, myofascial tenderness into the dorsal compartment of the bilateral forearm, negative Tinel's sign over the cubital and carpal tunnels, no gross motor deficits, and negative bilateral Finkelstein tests. The treating physician has not documented objective evidence of derived functional improvement from completed physical therapy sessions, nor the medical necessity for additional physical therapy to accomplish a transition to a dynamic home exercise program. The criteria noted above not having been met, Physical therapy x12 visits is not medically necessary.

Trigger point injections, BUE, x10: Upheld

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

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

Decision rationale: The requested Trigger point injections, BUE x10, is not medically necessary. Chronic Pain Medical Treatment Guidelines, Trigger Point Injections, Page 122, note 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. The injured worker has bilateral forearm pain. The treating physician noted the pain was greater in the forearm's dorsal compartment, and it seemed to originate from the elbows into the extensor compartment. There was rare distally radiating pain with more vigorous activity. The treating physician has documented tenderness of the bilateral lateral epicondyle, resisted extension and supination with minimal pain, myofascial tenderness into the dorsal compartment of the bilateral forearm, negative Tinel's sign over the cubital and carpal tunnels, no gross motor deficits, and negative bilateral Finkelstein tests. The treating physician has not documented a twitch response on physical exam. The criteria noted above not having been met, Trigger point injections, BUE, x10 is not medically necessary.