MAXIMUS Federal Services

| Case Number: | CM15-0073986 | | |
|---|---|---|---|
| Date Assigned: | 04/24/2015 | Date of Injury: | 07/17/2014 |
| Decision Date: | 07/07/2015 | UR Denial Date: | 04/11/2015 |
| Priority: | Standard | Application Received: | 04/17/2015 |

## 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: Pennsylvania, Ohio, California
Certification(s)/Specialty: Physical Medicine & Rehabilitation

## 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 37-year-old male, who sustained an industrial injury on 7/17/14. Initial complaints are not noted. The injured worker was diagnosed as having cervicogenic headaches, cervical sprain/strain; lumbar sprain/strain; lumbosacral or thoracic radiculitis Unspec; shoulder sprain/strain; cervical radiculitis; thoracic sprain/strain; lumbar region injury. Treatment to date has included acupuncture; physical therapy; TENS unit; medications. Diagnostics included x-rays cervical, thoracic, bilateral shoulders, and lumbar spine (9/29/14); EMG/NCV lower extremities (11/26/14). Currently, the PR-2 notes dated 1/20/15 indicate the injured worker complains of chronic low back, neck and bilateral shoulder pain radiating down the upper extremities to fingers three through five with numbness and tingling on the left and right and low back pain that radiates down the left lower extremity. Also he continues to have occasional headaches in which acupuncture decreases pain by 75%. On this visit, the injured worker mentions that he wishes to increase his activity level and exercise level to overcome this injury. He will start cardio strengthening and try to reduce medications use. The treatment plan included a heating pad, cervical traction, EMG/NCV upper extremities, lab draw, continue to use TENS unit, acupuncture and home exercise, consider a left shoulder MRI and epidural. Although the submitted documentation does not contain the requested services or the PR-2 reviewed at Utilization Review, there is submitted documentation of a letter dated 5/1/15 addressed to Independent Medical Review Organization. This letter states that request for Trigger point injection, Diclofenac 100mg ER #60, Referral to PMR specialist for epidural injections, and

Referral to orthopedist for left shoulder injections were approved in-house on 4/8/15 per the report dated 3/20/15.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Trigger point injection:** Upheld

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

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

**Decision rationale:** A 3//15 letter from the insurance carrier states that trigger point injections were certified on 3/9/15. The current request is not specific as to the date/location/quantity of injections request nor regarding the outcome of the prior approval. Thus, this request appears to be a duplicate and/or appears to have insufficient clinical detail to support the request. The request is not medically necessary.

**Diclofenac 100mg ER #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines non-steroidal anti-inflammatory drugs.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatories Page(s): 22.

**Decision rationale:** A letter from the insurance carrier of 5/1/15 states that this requested treatment was approved on 4/8/15. Therefore, the current request appears to be a duplicate. Therefore not applicable and not medically necessary.

**Referral to PMR specialist for epidural injections:** Overturned

**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 Epidural Steroid Injection Page(s): 46.

**Decision rationale:** A letter from the insurance carrier of 5/1/15 states that a cervical epidural injection was approved on 4/8/15. It follows that a PM&R referral to administer the approved ESI is supported by the same guideline. The request is thus medically necessary.

**Referral to orthopedist for left shoulder injections:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder (Acute & Chronic).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204.

**Decision rationale:** A letter from the insurance carrier of 5/1/15 states that this requested treatment was approved on 4/8/15. Therefore, the current request appears to be a duplicate. Therefore not applicable and not medically necessary.