

<b>Case Number:</b>	CM15-0126206		
<b>Date Assigned:</b>	07/29/2015	<b>Date of Injury:</b>	04/15/2013
<b>Decision Date:</b>	10/06/2015	<b>UR Denial Date:</b>	06/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/30/2015

### 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: New York, West Virginia, Pennsylvania  
 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 51-year-old female, who sustained an industrial injury on 04-15-2013. On provider visit dated 04-07-2015 the injured worker has reported right shoulder pain, right elbow pain, left wrist pain with weakness, numbness and tingling. The injured worker was noted to be status post right shoulder cortisone injections 04-06-2015 and carpal tunnel release surgery on 02-2013. On examination of the cervical spine was decreased and a positive Spurling sign was noted. Foramina compression test was noted as having tightness and spasm at the trapezius and sternocleidomastoid muscles. Right shoulder was noted to have positive impingement test and tenderness of rotator cuff. Left wrist was noted to have a decreased range of motion and positive DeQuervain's of left thumb. Left shoulder range of motion was decreased and positive impingement test was noted as well tenderness was noted at rotator cuff, infraspinatus, and supraspinatus and biceps tendon. Subacromial grinding and clicking was noted. The diagnoses have included cervical spine sprain-strain herniated cervical disc, left shoulder sprain-strain rule out tendinitis-impingement- rotator cuff tear, sprain-strain elbows. Left hand strain-strain-tendinitis-carpal tunnel syndrome and left wrist sprain-strain-internal derangement, anxiety and depression. Treatment to date has included physical therapy, acupuncture, chiropractic care and cortisone injections and medication including Norco. The provider requested internal medicine clearance for injections, ultrasound guided cortisone injections to the left wrist, left elbow and left shoulder, aqua therapy 2x5 for the left shoulder, Norco, Ambien and Remeron.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Internal medicine clearance for injection: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Pre-op testing.

**Decision rationale:** Preoperative testing may be performed before surgical procedures depending on the patient's clinical history, comorbidities, and physical exam findings. In this case, the claimant is not going to be under general sedation nor is the injection considered a surgical procedure. The request for internal medicine clearance is not medically appropriate and necessary.

### **U/S guided Cortisone injection to the left wrist: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Forearm, wrist and hand.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, and Hand.

**Decision rationale:** Guidelines state that injection alone and without splinting, is the best therapeutic approach for de Quervain's tenosynovitis. In this case, the claimant's DeQuervain's tenosynovitis has proven recalcitrant of other treatments. The request for steroid injection with ultrasound guidance is medically appropriate and necessary.

### **U/S guided Cortisone injection to the Left elbow: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Elbow.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Elbow chapter, injections.

**Decision rationale:** Guidelines state that that injection is not routinely recommended for epicondylitis. In this case, the documentation provided describes elbow sprain/strain injuries and there is no clear rationale identifying the medical necessity of ultrasound guidance injection for this patient. The request for ultrasound-guided injection of the elbow is not medically necessary and appropriate.

**U/S guided Cortisone injection to the left shoulder:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, injections.

**Decision rationale:** Guidelines do not support use of ultrasound for guidance of glucocorticoid injection for shoulder disorders over landmark-guided injection. The request for ultrasound-guided injection for the left shoulder is not medically necessary and appropriate.

**Aquatic therapy 2 x 5 for the left shoulder:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder.

**Decision rationale:** Guidelines state that aquatic therapy is specifically recommended where reduced weight bearing is desirable. Guidelines state that during physical therapy, fading of treatment frequency plus active self-directed home physical medicine should occur. In this case, the patient could have undergone home therapy including a pulley system for stretching and strengthening. There was no rationale given for the use of aquatic therapy of the shoulder. The request for aquatic therapy is not medically necessary and appropriate.

**Norco 10/325mg #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids for chronic pain.

**Decision rationale:** Guidelines recommend use of opioids long term if the patient has returned to work and if the patient has improved functioning and pain. In this case, the patient has musculoskeletal pain 2 years after injury. However, as of 5/19/15, the patient was not working. The request for Norco 10/325 mg #60 is not medically necessary and appropriate.

**Ambien 10mg #30:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Zolpidem.

**Decision rationale:** Guidelines recommend Ambien for short-term use in patients with insomnia. According to the submitted medical records, there is no documentation of insomnia. The request for Ambien 10 mg #30 is not medically necessary and appropriate.

**Remeron 15mg #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antidepressants for chronic pain.

**Decision rationale:** Guidelines state that Remeron is indicated in the treatment of major depressive disorder. In this case, the claimant does not have ongoing depressive symptoms. The request for Remeron 15 mg #30 is not medically appropriate and necessary.