

Case Number:	CM14-0103301		
Date Assigned:	09/24/2014	Date of Injury:	02/04/2000
Decision Date:	10/24/2014	UR Denial Date:	06/16/2014
Priority:	Standard	Application Received:	07/03/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Illinois. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 47-year-old male who reported an injury on 02/04/2000. The mechanism of injury was not provided. The injured worker's diagnoses included mid back pain, chronic pain syndrome, fragments of torsion dystonia, chronic headache disorder, cervical dystonia, myofascial pain, chronic low back pain, degeneration of lumbar or lumbosacral intervertebral disc, lumbosacral spondylosis without myelopathy, spasm of muscle, chronic insomnia, migraine with intractable migraine, and encounter for long term use of high risk medication. The injured worker's past treatments included physical therapy, medications, and botulin injections. The injured worker's diagnostic testing was not provided. The injured worker's surgical history was not provided. On the clinical note dated 08/06/2014, the injured worker complained of low back pain rated 5/10 with medications. The injured worker stated the medications were working well for pain control with no adverse side effects. The injured worker had tenderness, pain, and spasms to the thoracic spine, decreased range of motion, tenderness, bony tenderness, and pain and spasms to the lumbar spine. The injured worker's medications included Norco 10/325 mg, Soma 350 mg, and Tizanidine 4 mg. The request is for trigger point injections monthly to the thoracic, and physical therapy. The rationale for the request was not provided. The Request for Authorization form was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Trigger Point Injections Monthly to Thoracic: 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. Page(s): 122..

Decision rationale: The request for Trigger Point Injections Monthly to Thoracic is not medically necessary. The injured worker is diagnosed with mid back pain, chronic pain syndrome, fragments of torsion dystonia, and myofascial pain. The injured worker complains of low back pain rated 5/10. The California MTUS Guidelines recommend trigger point injections only for myofascial pain syndrome as indicated below with limited lasting value. Trigger point injections with a local anesthetic may be recommended for the treatment of chronic low back pain or neck pain with myofascial pain syndrome when all of the following criteria are met: documentation of circumscribed trigger points with evidence upon palpitation of a twitch response as well as referred pain, symptoms have persisted for more than 3 months, medical management therapy, such as ongoing stretching exercises, physical therapy, NSAIDs, and muscle relaxants have failed to control pain. Radiculopathy is not present by exam, imaging, or neuro testing, and not more than 3 to 5 injections per session, no repeat injections unless a greater than 50% pain relief is obtained for 6 weeks after an injections, and there is documented evidence of functional improvement. Frequency should not be at an interval less than 2 months. Trigger point injections with any substance other than local anesthetic, with or without steroid, are not recommended. There is a lack of documentation of circumscribed trigger points with evidence upon palpitation of a twitch response as well as referred pain, length of time of the symptoms have persisted for, other therapies to have failed to control pain. There is a lack of documentation indicating that radiculopathy is not present by exam, imaging, or neuro testing. The request is for injections monthly. The guidelines recommend injections not to be at less than 2 month intervals. Additionally, the request does not indicate the number of trigger point injections or the circumscribed trigger points in the thoracic in which to be injected. As such, the request for Trigger Point Injections Monthly to Thoracic is not medically necessary.

Physical Therapy (no frequency duration body part indicated): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE, Page(s): 98-99..

Decision rationale: The request for Physical Therapy (no frequency duration body part indicated) is not medically necessary. The injured worker is diagnosed with mid back pain, chronic pain syndrome, fragments of torsion dystonia, chronic headache disorder, cervical dystonia, myofascial pain, chronic low back pain, degeneration of lumbar intervertebral disc, lumbosacral spondylosis without myelopathy, spasm of muscle, chronic insomnia, migraine with intractable migraine, and encounter for long term current use of high risk medication. The injured worker complains of low back pain rated 5/10. The California MTUS Guidelines recommend active therapy is based on the philosophy that therapeutic exercise and/or activity are

beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. The medical records lacked documentation of significant functional deficits. The medical records did not indicate the rationale for the physical therapy. There is a lack of documentation indicating the amount of physical therapy and the efficacy of the prior therapy. There is a lack of documentation indicating improved pain rating and functional deficits from previous physical therapy. Additionally, the request does not indicate the frequency, duration, or body part for physical therapy. As such, the request for Physical Therapy (no frequency duration body part indicated) is not medically necessary.