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| <b>Case Number:</b>   | CM14-0158582 |                              |            |
| <b>Date Assigned:</b> | 10/02/2014   | <b>Date of Injury:</b>       | 11/13/1997 |
| <b>Decision Date:</b> | 10/29/2014   | <b>UR Denial Date:</b>       | 09/16/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 09/26/2014 |

### 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 & Rehabilitation and is licensed to practice in Texas. 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:

Medical records reflect the claimant is a 50 year old male who sustained a work injury on 11-13-97. Office visit on 9-9-14 notes eth claimant has low back pain with intermittent bilateral lower extremity numbness. The pain is rated as 6/10. The claimant is currently working on weaning off his current medications. The claimant is status post L4-S1 fusion. On exam, the claimant has normal DTR, decreased sensation at L4-L5, tenderness to palpation over the paraspinal muscles and right sacroiliac joint. There is diffuse tenderness noted over the right buttocks region and the claimant ambulates with an antalgic gait.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Bilateral Trigger Point Injection under Ultrasound-Sacral:** Upheld

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

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

**Decision rationale:** Chronic Pain Medical Treatment Guidelines notes that 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. There is an absence in documentation noting that this claimant has palpation of a twitch response as well as referred pain. Additionally, the claimant reports that back pain with intermittent bilateral lower extremity numbness. Trigger point injections are not recommended if radiculopathy is present. Therefore, the medical necessity of this request is not established. The request for Bilateral Trigger Point Injection under Ultrasound-sacral is not medically necessary.

**Right Hip Injection under Ultrasound-Hip Corticosteroid 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 Hip & Pelvis (Acute & Chronic) (Updated 03/25/2014)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG) hip and pelvis chapter - intraarticular steroid injection

**Decision rationale:** ODG notes that intraarticular steroid injections are not recommended in early hip osteoarthritis (OA). Under study for moderately advanced or severe hip OA, but if used, should be in conjunction with fluoroscopic guidance. Recommended as an option for short-term pain relief in hip trochanteric bursitis. There is an absence in documentation noting that this claimant has bursitis or moderately advanced or severe hip osteoarthritis. Therefore, the medical necessity of this request is not established. The request for Right Hip Injection under Ultrasound-Hip Corticosteroid Injection is not medically necessary.