

<b>Case Number:</b>	CM14-0093685		
<b>Date Assigned:</b>	07/25/2014	<b>Date of Injury:</b>	10/01/2003
<b>Decision Date:</b>	09/30/2014	<b>UR Denial Date:</b>	06/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/20/2014

### 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 Internal Medicine, has a subspecialty in Pulmonary Diseases and is licensed to practice in California. 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 39-year-old male who reported an injury on 10/01/2003. Prior therapies were noted to include physical therapy, chiropractic care, trigger point injections, and medication. The injured worker underwent an MRI of the lumbar spine. The injured worker's medication included opiates as of at least early 2013. The mechanism of injury was the injured worker was attacked by a swarm of bees and suffered insect stings on his face, neck, and eye. The injured worker had been prescribed Prednisone for which he had a serious reaction. Prior therapies include Orthovisc injections, a cortisone injection, physical therapy, chiropractic care, and medications. Prior studies included MRIs of the cervical, thoracic, and lumbar spine. The documentation of 09/16/2013 revealed the injured worker had trigger point injections to the cervical spine on 09/05/2013. The injured worker had pain in the left knee, right knee, and right eye and head that had remained unchanged. The injured worker had pain in the lumbar spine. The injured worker has taking medications and tolerating them. Medications included Fexmed 7.5 mg tablets (1 tablet daily) and oxycodone HCl 10 mg tablets (one 4 times a day). The diagnosis included occipital neuropathy, neuralgia, disc bulging, lumbar facet arthropathy and sacroiliac dysfunction. The treatment plan included a urine drug screen, a refill of medications, and lumbar trigger point injections at bilateral L4-5. Additional procedures included a bilateral sacroiliac joint injection. The application for Independent Medical Review form requesting the determination was dated 06/12/2014. There was no Request for Authorization form submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective request for 1 (one) bilateral injection at L4-L5 (DOS 09/16/2014): 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): 121, 122.

**Decision rationale:** The California MTUS Guidelines recommend trigger point injections for myofascial pain syndrome. They are not recommended for radicular pain. The criteria for the use of trigger point injections include documentation of circumscribed trigger points with evidence upon palpation of a twitch response and referred pain. There should be documentation that symptoms have persisted for more than 3 months and medical management therapy such as ongoing stretching exercises, physical therapy, NSAIDs, and muscle relaxants have failed to control pain. There should be documentation that radiculopathy is not present by physical therapy, imaging, or neurologic testing. There were no physical examination findings submitted for review. There was a lack of documentation meeting the above criteria. Additionally, the request as submitted failed to indicate the type of injection being requested, and there was no note with the date of 09/16/2014. The application for Independent Medical Review was dated prior to the requested date of service. Given the above, the retrospective request for 1 (one) bilateral injection at L4-L5 (DOS 09/16/2014) is not medically necessary.

**Retrospective request for 1 bilateral sacroiliac injection (DOS 09/16/2014): Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip & Pelvis Chapter, Sacroiliac joint blocks.

**Decision rationale:** The Official Disability Guidelines indicate that the criteria for the use of sacroiliac blocks include the history and physical should suggest a diagnosis with documentation of at least 3 positive examination findings including the cranial shear test, the extension test, the flamingo test, the Fortin finger test, the Gaenslen's Test, Gillet's Test, Patrick's test, pelvic compression test, pelvic distraction test, pelvic rock test, resisted abduction test, sacroiliac shear test, standing flexion test, seated flexion test, or the thigh thrust test. There should be documentation that other pain generators have been addressed. There should be documentation the injured worker had trialed and failed at least 4 to 6 weeks of aggressive conservative therapy including physical therapy, home exercise, and medication management. The clinical documentation submitted for review failed to provide an objective physical examination to support the request. There was a lack of documentation of the above criteria. The application for Independent Medical Review was dated prior to the requested date of service. Given the above, the retrospective request for 1 bilateral sacroiliac injection (DOS 09/16/2014) is not medically necessary.

**Retrospective request for 1 prescription Oxycodone Hcl 10mg #60 (DOS 09/16/2014):**  
Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain; ongoing management Page(s): 60; 78.

**Decision rationale:** The California MTUS Guidelines recommend opiates for the treatment of chronic pain. There should be documentation of objective functional improvement, an objective decrease in pain, and documentation the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review failed to meet the above criteria. The duration of use could not be established through supplied documentation. The request as submitted failed to indicate the frequency for the requested medication. The application for Independent Medical Review was dated prior to the requested date of service. There were no notes dated 09/16/2014. Given the above, the retrospective request for 1 prescription Oxycodone Hcl 10mg #60 (DOS 09/16/2014) is not medically necessary.