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| Case Number: | CM15-0057094 | | |
| Date Assigned: | 04/01/2015 | Date of Injury: | 09/17/2004 |
| Decision Date: | 05/01/2015 | UR Denial Date: | 03/24/2015 |
| Priority: | Standard | Application Received: | 03/25/2015 |

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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 was a year 52 old male, who sustained an industrial injury, September 17, 2004. The injured worker previously received the following treatments Norco, Skelaxin, Lidoderm, Celebrex, Halcion, X-ray of the lumbar spine, laminectomy, CT scan of the lumbar spine, lumbar spine MRI, epidural steroid injection, heat treatment, physical therapy, TENS (transcutaneous electrical nerve stimulator) unit, trigger point injection, facet joint injection and acupuncture. The injured worker was diagnosed with lumbago/left iliolumbar ligament, postlaminectomy syndrome lumbar spine, lumbosacral neuritis bilaterally, chronic postoperative pain, joint pain right leg MCL and meniscus. According to progress note of March 24, 2015, the injured workers chief complaint was persistent lumbar spine pain. The physical exam noted paravertebral thoracic spasm, left thoracolumbar spasm, left lateral hip. The straight leg raises were negative bilaterally in a seated position. Faber was negative firth right and positive on the left. The injured worker had a compensated gait. The treatment plan included orthopedic trigger point injections at the right iliac crest distribution and physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Orthopedic trigger point injections, right iliac crest distribution: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger point injections Page(s): 124.

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

Decision rationale: The claimant is more than 10 years status post work-related injury and continues to be treated for low back pain with a recent exacerbation of symptoms. When seen, the note references a left iliolumbar trigger with hypertonicity. There was no described referred pain pattern. He was participating in physical therapy. Return to work was planned in three days. Criteria for the use of trigger point injections include documentation of the presence of a twitch response as well as referred pain. In this case, the presence of a twitch response with referred pain is not documented and therefore a trigger point injection was not medically necessary.

Physical therapy Qty: 12.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Physical therapy guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (1) Chronic pain, Physical medicine treatment. (2) Preface, Physical Therapy Guidelines.

Decision rationale: The claimant is more than 10 years status post work-related injury and continues to be treated for low back pain with a recent exacerbation of symptoms. When seen, the note references a left iliolumbar trigger with hypertonicity. There was no described referred pain pattern. He was participating in physical therapy. Return to work was planned in three days. In terms of physical therapy treatment for chronic pain, compliance with a home exercise program would be expected and would not require continued skilled physical therapy oversight. Providing additional skilled physical therapy services would not reflect a fading of treatment frequency and would promote dependence on therapy provided treatments. The claimant has no other identified impairment that would preclude performing such a program. Therefore additional physical therapy was not medically necessary.