

Case Number:	CM14-0195698		
Date Assigned:	12/03/2014	Date of Injury:	11/01/2004
Decision Date:	01/16/2015	UR Denial Date:	10/21/2014
Priority:	Standard	Application Received:	11/21/2014

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, has a subspecialty in Interventional Spine 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 patient is a 49 year old female with an injury date on 11/01/2004. Based on the 09/23/2014 progress report provided by the treating physician, the diagnoses are:1. Sacroiliac joint arthropathy left side2. Possible right trapezius myofascial pain3. GERD4. InsomniaAccording to this report, the patient complains of "low back pain more than the left side, right side upper back pain." Severity of pain is 10/10 and with the help of medication it goes down to 4-5/10 and makes it tolerate. Physical exam reveals tenderness over the left L5-S1 facet, posterior superior iliac spine, and over the superior border of trapezius muscle on the left side. The 08/14/2014 report indicates the patient has numbness and tingling in the left leg. Patrick test and Gaenslen's test are positive. Right shoulder pain that radiates to neck. Treatment to date includes medications and sacroiliac joint block which helped more than 50% for at least four weeks. There were no other significant findings noted on this report. The utilization review denied the request for (1) Trigger point injections in three areas -right shoulder, low back, (2) Motorized cold therapy unit purchase, (3) Heating unit, and (4) Urine drug screen on 10/22/2014 based on the MTUS/ODG guidelines. The requesting physician provided treatment reports from 10/03/2013 to 09/23/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Trigger point injections in three areas (right shoulder, low back): Upheld

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

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

Decision rationale: According to the 09/23/2014 report, this patient presents with "low back pain more than the left side, right side upper back pain." The current request is for Trigger point injections in three areas (right shoulder, low back). Regarding trigger point injections, MTUS guidelines page 122 requires (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). In this case, the treating physician lists a diagnosis of myofascial pain but the examination does not show trigger points with taut band and referred pain pattern as required by the MTUS guidelines. Based on available information, the patient has shoulder radicular symptoms for which trigger point injections are not indicated. Therefore, the current request is not medically necessary.

Motorized cold therapy unit purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee Chapter online for DME, knee chapter under continuous-flow cryotherapy

Decision rationale: According to the 09/23/2014 report, this patient presents with "low back pain more than the left side, right side upper back pain." The current request is for Motorized cold therapy unit purchase "for the patient to be utilized post injection." Regarding cold therapy, ODG guidelines "recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use." Review of the reports, the treating physician did not document that the patient is scheduled for any surgery. ODG does not support cold therapy unit for chronic pain. It can be used for post-operative care. The request is not medically necessary.

Heating unit: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic) chapter, Heat therapy

Decision rationale: According to the 09/23/2014 report, this patient presents with "low back pain more than the left side, right side upper back pain." The current request is for Heating unit. Regarding heat therapy, ODG guidelines state "Recommended. Combining continuous low-level heat wrap therapy with exercise during the treatment of acute low back pain significantly improves functional outcomes compared with either intervention alone or control." Heat therapy has been found to be helpful for pain reduction and return to normal function." In this case, the treating physician has recommended a heating unit which had helped the patient back pain in the past; and ODG recommends this as an option. The request is medically necessary.