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| Case Number: | CM14-0216997 | | |
| Date Assigned: | 01/06/2015 | Date of Injury: | 07/20/2013 |
| Decision Date: | 03/03/2015 | UR Denial Date: | 12/17/2014 |
| Priority: | Standard | Application Received: | 12/29/2014 |

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. 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: California
 Certification(s)/Specialty: Family Practice

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 43 year old male was a store associate when he sustained an injury to the right hip on July 20, 2013. The injured worker injured when he was pulling shopping carts when he felt a tug in the lower groin area and then flipping a flatbed cart. The diagnoses and results of the injury include impingement syndrome with predominate cam impingement of the right hip, probable labral pathology with minimal degenerative changes, lumbosacral sprain, and hip/thigh sprain. Past treatments included x-rays, MRI, right hip injection, acupuncture and muscle relaxant, pain and anti-epilepsy medications. On August 6, 2013, an MRI of the right hip revealed moderate osteoarthritis secondary to a mixed type of femoroacetabular impingement with cam morphology and prominent posterior acetabular wall. There were articular cartilage abnormalities at the peri-labral acetabular cartilage and the anterior and medial aspect of the femoral head, and an area of delamination in the femoral head superiorly and medially, which is superior and lateral to the femoral attachment side of the ligamentous teres. On November 31, 2013, the injured worker underwent a right hip diagnostic arthroscopy, acetabuloplasty, labral stabilization, and femoroplasty. Post-operatively, the injured worker was treated with crutches, partial weight bearing, activity modification, home exercise program, and a course of physical therapy. On November 21, 2014, the treating physician noted mild to moderate cramping, deep, achy, shooting right groin pain. Associated symptoms included depressed, difficulty concentrating, recent increase in left hip pain from favoring the right side, and occasional low back stiffness. The physical exam revealed the injured worker was able to get on and off the exam table without assistance or apparent difficulty. He was able to walk with a relatively

normal gait but did complain of anterior right hip pain with walking on heel/toes and performing tandem gait. The right hip exam revealed normal anterior and posterior inspection, anterior tenderness extending to the pubic region just below the inguinal ligament, moderately decreased range of motion, normal strength, and normal Trendelenburg, Log Roll, and Scouring tests. The lower extremities had normal musculature, no localizing tenderness other than noted in the hip exam, normal strength, range of motion was good and without evidence of instability, intact sensation, and normal reflexes. Straight leg raise and Lasegue's testing was negative bilaterally. Diagnoses were status post right hip and groin strain/sprain, status post right hip arthroscopy, persistent right hip and groin pain, and chronic pain syndrome. Currently, the injured worker was treated with pain medication. The physician recommended starting chiropractic care, soft tissue injection in the area for diagnostic and therapeutic purposes, and an anti-epilepsy medication. Current work status is temporarily totally disabled. On December 17, 2014, Utilization Review non-certified a request for a localized trigger point injection to the groin area x1 requested on December 10, 2014. The localized trigger point injection to the groin area was non-certified based on the lack of documentation of circumscribed trigger points with evidence of twitch response upon palpation as well as referred pain; symptoms persisted longer than three months, and medical management, such as on-going stretching exercises, physical therapy, non-steroidal anti-inflammatory drugs and muscle relaxants have failed to control pain prior to the request. The California Medical Treatment Utilization Schedule (MTUS), Chronic Pain Medical Treatment Guidelines: Trigger Point Injections - Criteria for the use of Trigger point injections were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Localized trigger point injection to groin area: 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 Trigger point injection Page(s): 122.

Decision rationale: This patient has had arthroscopic surgery of the right hip, followed by physical therapy and a home exercise program. Despite these treatments the patient complains of chronic right hip and groin pain. The guidelines require a number of clinical features to be present in order to recommend a trigger point injection. These clinical factors include: (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. The documentation fails to establish that a twitch response is elicited along with a referred pain after palpation. Based on the documentation, a trigger point injection is not medically indicated.