

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM15-0109318 | | |
| Date Assigned: | 06/15/2015 | Date of Injury: | 11/04/1999 |
| Decision Date: | 07/17/2015 | UR Denial Date: | 06/01/2015 |
| Priority: | Standard | Application Received: | 06/05/2015 |

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: California, Texas, Florida

Certification(s)/Specialty: Anesthesiology, Pain Management, Hospice & Palliative Medicine

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 55 year old man sustained an industrial injury on 11/4/1999. The mechanism of injury is not detailed. Diagnoses include low back pain, left side sacroiliac joint syndrome, depression due to chronic pain, right knee pain. Treatment has included oral and topical medications and spinal cord stimulator trial. Physician notes dated 4/6/2015 show complaints of dull mid back pain rated 7/10. Recommendations include thoracic spine x-ray series, Elavil, Lidoderm patches, Voltaren gel, Ibuprofen, and follow up in two months.

IMR ISSUES, DECISIONS AND RATIONALES

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

Trigger Point Injection x's 2 to Thoracolumbar: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 122. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Trigger Point Injections.

Decision rationale: Regarding the request for trigger point injections, Chronic Pain Medical Treatment Guidelines support the use of trigger point injections after 3 months of conservative treatment provided trigger points are present on physical examination. ODG states that repeat trigger point injections may be indicated provided there is at least 50% pain relief with reduction in medication use and objective functional improvement for 6 weeks. Within the documentation available for review, there are no physical examination findings consistent with trigger points, such as a twitch response as well as referred pain upon palpation. Additionally, there is no documentation of failed conservative treatment for 3 months to the trigger point area. In the absence of such documentation, the requested trigger point injections are not medically necessary.