

Case Number:	CM15-0117278		
Date Assigned:	06/25/2015	Date of Injury:	04/24/2001
Decision Date:	07/30/2015	UR Denial Date:	06/09/2015
Priority:	Standard	Application Received:	06/17/2015

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:

The injured worker is a 52-year-old female who sustained an industrial injury on 04/24/2001. Mechanism of injury was a slip and fall. Diagnoses include left knee degenerative joint disease, status post total knee replacement, right upper extremity CRPS, status post spinal cord stimulator and subsequent removal, right elbow medial and lateral epicondylitis, sacro-coccygeal pain, right ulnar neuritis, depression related to pain, and left wrist and hand pain/tendonitis related to cane use. Treatment to date has included diagnostic studies, medications, spinal cord implantation, 2 or 3 arthroscopic surgeries followed by a left knee replacement, previous sacrococcygeal block with benefit, and therapy. Her medications include Lyrica, Cymbalta, Endocet, Colace, Lunesta, Amrix, Diltiazem, and Levothyroxine. A physician progress note dated 06/03/2015 documents the injured worker complains of right elbow, and wrist pain as well as the left knee and low back, and sacrococcygeal pain. She rates her focal lumbo-thoracic and coccygeal pain as 8 out of 10 with medications, and 10 out of 10 without medications. She has a slow antalgic gait and uses a cane. Quality of sleep is poor. Her cervical spine range of motion is limited and painful. The thoracic spine shows paravertebral muscles with hypertonicity, spasm, tenderness and tight muscle band is noted on both sides. She has sacrococcygeal pain, trigger point with radiating pain and twitch response on palpation at the lumbar paraspinal muscle on the left and right. The treatment plan includes 6-month gym membership to include aquatic therapy, adjustable mattress, medications were refilled, and computed tomography scan for lumbar/sacral fracture or herniation. Treatment requested is for 1 Sacro-coccygeal block with steroid under fluoroscopic guidance.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Sacro-coccygeal block with Steroid Under Fluoroscopic guidance: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Ochsner J. 2014 Spring; 14(1): 84-87.

Decision rationale: Regarding the request for a repeat sacrococcygeal injection, CA MTUS and ODG are silent in regards to sacrococcygeal injections specifically. However, they do generally discuss local injections being of questionable merit. Literature does suggest injections as part of a more global multidisciplinary approach at treating coccyx pain. Conservative measures also include pelvic floor rehabilitation, manual manipulation, and massage. Within the documentation available for review, there is no indication of percent pain relief or decrease in VAS with associated reduction of medication use as well as objective functional improvement from previous sacrococcygeal injection. Additionally, there is no documentation of failure of other conservative measures like physical therapy. In the absence of clarity regarding these issues, the currently requested a repeat sacrococcygeal injection is not medically necessary.