

Case Number:	CM13-0027142		
Date Assigned:	11/22/2013	Date of Injury:	08/14/2009
Decision Date:	02/12/2014	UR Denial Date:	09/04/2013
Priority:	Standard	Application Received:	09/20/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, and is licensed to practice in New York and Texas. 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 physician 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 39-year-old male who reported a work-related injury on 08/14/2009. The specific mechanism of injury was not stated. The patient subsequently presents for treatment of the following diagnoses: clinically consistent left lumbar radiculopathy, chronic low back pain, bilateral sacroiliitis, and degenerative disc disease. The provider documents the patient presents with a rate of pain at 8/10. Upon physical exam of the patient, tenderness was noted about the lumbar facet joints bilaterally left greater than right. Straight leg raise aggravated low back pain with radiation to the left hip and thigh without radiation to the left leg. Dysesthesias was noted to light touch in the left L5 dermatome. The provider rendered a prescription for Tizanidine 4 mg by mouth at bedtime.

IMR ISSUES, DECISIONS AND RATIONALES

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

left sacroiliac joint injection: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip and Pelvis Chapter

Decision rationale: The current request is not supported. The clinical documentation submitted for review fails to evidence the patient presents with significant sacroiliac joint dysfunction to support the requested intervention. The Official Disability Guidelines indicate there must be documentation of at least 3 positive exam findings to include evidence of sacroiliac joint dysfunction. Given the lack of evidence of objective findings of symptomatology upon physical exam of the patient, the request for one (1) left sacroiliac joint injection is neither medically necessary nor appropriate.

Physical therapy two (2) times a week for three (3) to four (4) weeks: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 99.

Decision rationale: The current request is not supported. The clinical documentation submitted for review reports the patient presents with continued lumbar spine pain complaints status post a work-related injury sustained in 2009. There was a lack of documentation evidencing when the patient last utilized supervised therapeutic interventions and the efficacy of treatment. Given that the patient is status post his work-related injury of over 4 years' time, at this point in the patient's treatment an independent home exercise program would be indicated. As California MTUS states to allow for fading of treatment frequency from up to 3 visits per week to 1 or less plus active self-directed home physical medicine. Given the above, the request for physical therapy two (2) times a week for three (3) to four (4) weeks is neither medically necessary nor appropriate.