

Case Number:	CM13-0042904		
Date Assigned:	12/27/2013	Date of Injury:	08/30/2012
Decision Date:	02/25/2014	UR Denial Date:	10/11/2013
Priority:	Standard	Application Received:	10/21/2013

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 & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Oklahoma 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 25-year-old female who reported an injury on 08/31/2012 as a result of bending down and pushing a box on the floor. This motion reportedly resulted in low back pain radiating into the right lower extremity. The patient's most recent clinical examination findings included tenderness to palpation and spasming over the left L5-S1, L4-5, and L3-4 levels with restricted range of motion secondary to pain. The clinical documentation also indicates that the patient had decreased sensation over the right dorsal foot and dorsal lateral leg. The patient had a straight leg raising test to 90 degrees radiating into the right lower extremity. The patient had positive hip internal and external rotation, a positive Gillet's sign, positive Yeoman's sign, a positive Patrick's sign, and a positive Faber sign to the right lower extremity. The patient also had a positive femoral thrust sign of the right lower extremity. Previous treatments included medications, physical therapy, and acupuncture. The patient's diagnoses included lumbar disc injury, right sacroiliac arthralgia, right sciatica, rib strains, and complex regional pain syndrome to the left upper extremity. The patient's treatment plan included transforaminal epidural steroid injections to the right L4-5 and L5-S1 levels and a right sacroiliac joint injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Transformational epidural injection right L4-5, L5-S1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Hip and Pelvis.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46.

Decision rationale: The requested transforaminal epidural steroid injection to the right L4-5 and L5-S1 is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has radicular pain. California Medical Treatment Utilization Schedule recommends the use of epidural steroid injections for patients who have clinical findings of radiculopathy that are supported by an imaging study and recalcitrant to conservative measures. The clinical documentation submitted for review does provide evidence that the patient's pain has failed to respond to conservative treatment to include physical therapy. However, an official interpretation of an imaging study was not submitted for review to support the need for an epidural steroid injection. Clinical documentation submitted for review does indicate that the patient previously underwent an MRI; however, without an official independent interpretation, medical necessity cannot be determined. As such, the requested transforaminal epidural injection at the right L4-5, L5-S1 is not medically necessary or appropriate.

Right sacroiliac joint injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Hip and Pelvis.

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, Sacroiliac joint blocks.

Decision rationale: The requested right sacroiliac joint injection is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has sacroiliac joint pain. However, Official Disability Guidelines do not recommend the use of sacroiliac joint injections until all other pain generators have been ruled out. The clinical documentation submitted for review does provide evidence that the patient has multiple pain generators. As such, the right sacroiliac joint injection is not medically necessary or appropriate.