

Case Number:	CM13-0049854		
Date Assigned:	12/27/2013	Date of Injury:	05/20/2011
Decision Date:	07/29/2014	UR Denial Date:	10/29/2013
Priority:	Standard	Application Received:	11/08/2013

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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/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 injured worker is a 43-year-old male who reported an injury on 05/20/2011, caused by an unknown mechanism. On 09/03/2013, the injured worker complained of right hip and left wrist pain. It was noted that the MRI is inconclusive, therefore, an MR arthrogram of the left wrist should be performed, and it was noted that the injured worker was working. On 09/03/2013, the objective findings were tenderness present in the upper portion proximal to the greater trochanter region. It was noted the injured worker was able to squat and had full range of motion. The examination of the left wrist revealed tenderness present over the volar and medial aspect of the wrist just proximal to the rows and he had full range of motion. It was noted that the injured worker underwent an electrodiagnostic studies that revealed mild carpal tunnel. The medications included Naprosyn. The diagnoses included carpal tunnel syndrome/left wrist and bursitis right hip. There was no visual analogue scale scale measurements indicated for the injured worker or conservative care such as physical therapy. The request was for decision for a right S1 joint injection under fluoroscopy. The authorization for request was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

RIGHT S1 JOINT INJECTION UNDER FLUOROSCOPY: 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).

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

Decision rationale: The California Medical Treatment Utilization Schedule (MTUS) Guidelines and American College of Occupational and Environmental Medicine Guidelines do not address the request. The request for a decision for the right S1 joint injection under fluoroscopy is not medically necessary. The ODG recommends a joint injection under fluoroscopy as an option if failed at least 4 to 6 weeks of aggressive conservative therapy. The diagnoses included carpal tunnel syndrome of the left wrist and bursitis of the right hip. There was lack of evidence to identify sacroiliac dysfunction of the injured worker. There is no conservative care documented for the injured worker to include physical therapy, home exercise and medication management. Given the above, the request for the right S1 joint injection under fluoroscopy is not medically necessary.