

Case Number:	CM13-0064185		
Date Assigned:	01/03/2014	Date of Injury:	12/26/2010
Decision Date:	04/18/2014	UR Denial Date:	12/02/2013
Priority:	Standard	Application Received:	12/11/2013

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 Anesthesiology, and is licensed to practice in Florida. 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 patient is a 51-year-old female who reported an injury on 12/26/2010 due to repetitive work activity which reportedly caused a gradual onset of pain in her neck, shoulders, and low back. The patient's most recent clinical documentation noted that the patient had increasing low back pain with radicular symptoms and left sacroiliac joint pain. It was noted that the patient had previously undergone a bilateral transforaminal epidural steroid injection at the L3-4 with no reported improvement. Physical findings included limited lumbar range of motion described as 45 degrees in flexion, 20 degrees in extension, 20 degrees in lateral bending bilaterally, and 25 degrees in rotation bilaterally. Physical findings of the sacroiliac joint documented positive left-sided tenderness to palpation with a positive Fabere-Patrick test, positive Gaenslen's test, and a positive pelvic thrust test. It was noted that the patient had previously been treated with physical therapy, a home exercise program, and medication management. The patient's diagnoses included left sacroiliac joint dysfunction, bilateral shoulder tendonitis, cervical disc herniations, chronic neck pain, depression, multilevel disc protrusions, and status post right carpal tunnel release. The patient's treatment plan included tramadol, physical therapy, a sacroiliac joint injection, and an EMG/nerve conduction study for the left lower extremity.

IMR ISSUES, DECISIONS AND RATIONALES

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

SACROILIAC JOINT BLOCK: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Hip & Pelvis Chapter, section on Sacroiliac joint blocks

Decision rationale: The requested sacroiliac joint block is not medically necessary or appropriate. Official Disability Guidelines recommend sacroiliac joint blocks for patients who have failed at least 4 to 6 weeks of physical therapy, have at least 3 positive examination findings of sacroiliac joint dysfunction, and other possible pain generators have been addressed. The clinical documentation submitted for review does provide evidence that the patient has lumbar spine pathology that has not been addressed. Although the patient does have physical exam findings indicative of sacroiliac joint dysfunction and has failed to respond to conservative treatments, all other pain generators have not been ruled out at this time. Therefore, a sacroiliac joint block would not be indicated. As such, the requested sacroiliac joint block is not medically necessary or appropriate.

EMG/NERVE CONDUCTION STUDY, LEFT LOWER EXTREMITY: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

Decision rationale: ACOEM Guidelines recommend electromyography studies for patients who have radicular symptoms suggested during physical examination that do not clearly identify nerve root pathology. The clinical documentation submitted for review does not provide any objective evidence of radiculopathy. There are no objective findings to support motor strength deficits, and deficits of sensation. Though the patient does have subjective complaints of radiating pain, the patient's most recent clinical evaluation does not provide any evidence that the patient has radiculopathy. Therefore, the need for an electromyography study is not clearly identified. As such, the requested electromyography (EMG)/nerve conduction study of the left lower extremity is not medically necessary and appropriate.

TRAMADOL ER 150MG TWICE DIALY WITH 2 REFILLS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

Decision rationale: The MTUS Chronic Pain Guidelines recommend the continued use of opioids in the management of chronic pain be supported by documentation of functional benefit, a quantitative assessment of pain relief, managed side effects, and evidence that the patient is

monitored for aberrant behavior. The clinical documentation submitted for review does indicate that the patient has been on this medication since at least 08/2013. However, there is no documentation of functional benefit or pain relief. Additionally, there is no documentation that the patient is monitored for aberrant behavior. Therefore, continued use of this medication would not be supported. As such, the requested tramadol ER 150 mg, twice daily, with two (2) refills is not medically necessary or appropriate.

PT 6 SESSIONS: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: vThe MTUS Chronic Pain Guidelines recommend continued physical therapy be based on documentation of functional benefit. The clinical documentation submitted for review does indicate that the patient has previously participated in physical therapy without any functional benefit. Additionally, the submitted request does not identify what body parts would be targeted as a result of the requested physical therapy. Therefore, the appropriateness of the request cannot be determined. As such, the request for six (6) sessions of physical therapy is not medically necessary and appropriate.