

Case Number:	CM13-0066675		
Date Assigned:	01/03/2014	Date of Injury:	01/13/2011
Decision Date:	04/21/2014	UR Denial Date:	12/05/2013
Priority:	Standard	Application Received:	12/16/2013

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 & Rehabilitation, and is licensed to practice in Illinois. 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 60-year-old female who reported an injury on 01/13/2011 after a fall that reportedly caused injury to the patient's low back, right leg, and right knee. The patient's most recent clinical evaluation documented that the patient's right lower extremity pain and low back pain rated at a 5/10 to 6/10 that was described as constant. Physical findings of the right hip included full range of motion and an antalgic gait pattern. The patient's diagnoses included a lumbar strain, right hip sprain, right knee sprain and right ankle sprain. The patient's treatment recommendations included a sacroiliac joint injection to the right side, a bursa injection to the right trochlear, referral to a spine surgeon, and continuation of medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Spine Surgeon Consultation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306.

Decision rationale: The requested spine surgeon consultation is not medically necessary or appropriate. The clinical documentation submitted for review does not appropriately identify that the patient is a surgical candidate. The American College of Occupational and

Environmental Medicine recommends surgical intervention for patients who have significant functional deficits would benefit from surgical intervention and are supported by an imaging study and electrodiagnostic studies. The clinical documentation submitted for review does support that the patient is in a significant amount of pain that interferes with activities of daily living; however, the documentation does not include an imaging study that supports pathology that would benefit from surgical intervention. Therefore, consultation with a spine surgeon would not be medically necessary or appropriate.

Bursa Injection to the Right Trochlear: 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 and Pelvis chapter, Trochanteric bursitis injections

Decision rationale: The requested bursa injection to the right trochlear is not medically necessary or appropriate. Official Disability Guidelines do recommend corticosteroid injections to the trochlear region as a conservative measure; however, the clinical documentation submitted for review indicates that the patient's greater trochanteric, anterior hip joints and deep gluteal regions are not tender to palpation. Therefore, the patient's right trochlear is not identified as the patient's pain generator. As such, the requested bursa injection to the right trochlear is not medically necessary or appropriate.

SI Joint Injection on the Right: 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 and Pelvis Chapter, Sacroiliac Joint Blocks

Decision rationale: The requested sacroiliac joint injection on the right side is not medically necessary or appropriate. Official Disability Guidelines recommend sacroiliac joint blocks for patients who have at least 3 documented examination findings supporting the diagnosis of a sacroiliac joint dysfunction. The clinical documentation submitted for review does indicate that the patient has painful range of motion of the right hip. However, no other orthopedic examinations were provided to support the diagnosis of a sacroiliac joint dysfunction. These tests include, but are not limited to, a cranial shear test, extension test, flamingo test, Fortin finger test, Gaenslen's test, Gillett's test, Patrick's test, pelvic compression test, pelvic distraction test, pelvic rock test, resisted abduction test, sacroiliac shear test, standing flexion test, seated flexion test, and thigh thrust test. As there are no physical findings to support the diagnosis of a sacroiliac joint dysfunction, a sacroiliac joint injection would not be appropriate. As such, the requested sacroiliac joint injection on the right is not medically necessary or appropriate.

Klonopin 0.25mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: The requested Klonopin 0.25 mg #90 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not recommend the use of this medication for an extended duration as there is a significant risk for psychological and physiological dependence. The clinical documentation submitted for review does indicate that the patient has been on this medication since at least 01/2013. The clinical documentation submitted for review does not provide any exceptional factors to support extending treatment beyond guideline recommendations. Therefore, continued use of this medication would not be supported. As such, the requested Klonopin 0.25 mg #90 is not medically necessary or appropriate.

Soma 350mg #60: 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 Muscle Relaxants Page(s): 63.

Decision rationale: The requested Soma 350 mg #60 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not recommend the long-term use of muscle relaxants as appropriate treatment for chronic pain. The clinical documentation submitted for review does indicate that the patient has been on this medication since at least 01/2013. As the treatment duration of this medication has exceeded 2 to 3 week recommendation made by the California Medical Treatment Utilization Schedule and there are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations, continued use would not be supported. As such, the requested Soma 350 mg is not medically necessary or appropriate.

Prilosec 20mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68.

Decision rationale: The requested Prilosec 20 mg #30 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends and use of gastrointestinal protectant for patients who are at risk for developing gastrointestinal disturbances related to medication usage. The clinical documentation submitted for review does not provide an adequate assessment of the patient's gastrointestinal system to support the need for a gastrointestinal protectant. Therefore, continued use of this medication would not be supported. As such, the requested Prilosec 20 mg #30 is not medically necessary or appropriate

Norco 10/325mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management Page(s): 78.

Decision rationale: The requested Norco 10/325 mg #90 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends that continued use of opioids 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 01/2013. The clinical documentation does not provide any evidence that the patient is monitored for aberrant behavior. Additionally, there is no quantitative assessment of pain relief or documentation of functional benefit to support continued use of this medication. As such, the requested Norco 10/325 mg #90 is not medically necessary or appropriate