MAXIMUS Federal Services

Case Number:	CM13-0069669		
Date Assigned:	01/03/2014	Date of Injury:	12/10/2011
Decision Date:	05/27/2014	UR Denial Date:	12/17/2013
Priority:	Standard	Application Received:	12/23/2013

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 Pain Medicine 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 injured worker is a 33-year-old female who reported an injury on 12/10/2011. The mechanism of injury was the injured worker was covering for a doorman and helped unload 6 to 8 boxes weighing approximately 60 pounds plus. The injured worker started experiencing some numbness to her lower extremity. The piriformis tenderness test, piriformis stress tests were negative on the left. The sacroiliac tenderness, Faber's/Patrick's tests, sacroiliac stress test and Yeoman's test were positive on the left side. The injured worker had a positive Kemp's test bilaterally. The patient had a seated and supine straight leg raise that were positive on the left. The patient also has joint pain with left sided supine and seated straight leg raise. Farfan test was performed which positive bilaterally. The diagnosis included left sacroiliac arthropathy. The treatment recommendation was a left sacroiliac joint injection under fluoroscopic guidance as the injured worker had joint pain with 3 positive tests without radicular symptoms. It was indicated that the injured worker had failed conservative treatment including physical therapy, chiropractic care, medication, rest and home exercise. Additionally, it was indicated if the patient received greater than 80% relief from activity that normally caused the pain for the duration of the local anesthetic, the physician would consider a right sacroiliac joint Rhizotomy. Additionally, a treatment request was made for bilaterally L4-S1 bilateral medial branch blocks if the injured worker had axial pain with relief after the left sacroiliac joint injection or Rhizotomy, electrical muscle stimulation unit 30 day trial for home use, urine toxicology, and continuation of present medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

LEFT SACROILIAC JOINT INJECTION UNDER FLUOROSCOPIC GUIDANCE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

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 Chapter, Sacroiliac joint block.

Decision rationale: The Official Disability Guidelines (ODG) indicate sacroiliac joint blocks are appropriate when an injured worker has 3 positive examination findings including the Gaenslen's test test, Fortin finger test, flamingo test, extenstion test, crainal shear test, Gillet test test, Patrick/Faber test, pelvic distraction test, pelvic rock test, resisted abduction test, sacroiliac shear test, standing flexion test, seated flexion test, or the thigh thrust test. There should be documentation of failure of at least 4 to 6 weeks of aggressive conservative therapy including physical therapy, home exercises and medication management and blocks are performed under flouroscopy. The clinical documentation submitted for review indicated that the injured worker had a positive Faber's test, sacroiliac thrust test and Yeoman's test. It also indicated that the injured worker failed conservative treatments including physical therapy, chiropractic care, medications, rest and home exercise programs. However, there was lack of documentation for the duration of aggressive conservative therapy. The request for a left sacoriliac joint injection under fluroscopic guidance is not medically necessary.

ELECTRONIC MUSCLE STIMULATOR (ORTHOSTIM4 INTERFERENTIAL STIMULATOR) AND SUPPLIES FOR 30 DAYS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS' NMES' Interferential Current Stimulation Page(s): 115, 116, 121, 118.

Decision rationale: The California MTUS guidelines recommends a one month trial of a TENS unit as an adjunct to a program of evidence-based functional restoration for chronic neuropathic pain. Prior to the trial there must be documentation of at least three months of pain and evidence that other appropriate pain modalities have been tried (including medication) and have failed. They do not recommend Neuromuscular electrical stimulation (NMES devices) as there is no evidence to support its' use in chronic pain. MTUS Guidelines do not recommend Interferential Current Stimulation (ICS) as an isolated intervention. The Combo Care 4 stim unit includes, TENS, NMES/EMS, ISC and syncopation therapies into one unit. The clinical documentation submitted for review failed to document exceptional factors for the use of a neuromuscular electrical stimulation device as there is no evidence to support its use in chronic pain. There was a lack of documentation indicating that the injured worker would be utilizing the combo care 4 unit as an adjunct therapy. The request for electronic muscle stimulator (Ortho-Stim 4

interferential stimulator) and supplies for a 30 day trial is not medically necessary and appropriate.

URINE DRUG TESTING: 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 Chronic Pain Treatment Guidelines Ongoing Management Page(s): 78.

Decision rationale: California MTUS indicates that the use of urine drug screening is for patients with documented issues of abuse, addiction, or poor pain control. The clinical documentation submitted for review failed to indicate the injured worker had documented issues with abuse, addiction or poor pain control. The request for urine drug testing is not medically necessary and appropriate.