

Case Number:	CM14-0006682		
Date Assigned:	02/07/2014	Date of Injury:	08/11/2002
Decision Date:	06/23/2014	UR Denial Date:	12/17/2013
Priority:	Standard	Application Received:	01/17/2014

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 Occupational Medicine 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:

Injured worker is a male with date of injury 8/11/20013. Per primary treating physician's orthopedic spine surgery narrative progress report, the injured worker complains of daily and constan low back pain approximately ofe the SI joint, 10/10 on a VAS. He complains of daily and frequent pain approximately over the right greater trochanter, 10/10 on a VAS. He has complaints of daily and ongoing right leg pain, 10/10 on a VAS. On exam there is a significantly antalgic gait patter, favoring the left lower extremity. He utilizes a single point cane for ambulation. There is a well healed midline lumbar spine incision. There is palpable tenderness centrally in the lumbar spine. Senation is intact. Knee reflexes are 1+ bilaterally, ankle reflexes are absent on the right and 2+ on the left. Lower extremity strength is 5/5 throughout except bilateral ankle dorsiflexion is 4/5. Straigh leg raise is negative bilaterally at 90 degrees. Diagnoses include 1) cervical spondylosis, minimally symptomatic 2) right shoulder rotator cuff tear, status post repair 3) right shoulder AC joint and glenohumeral joint arthritis 4) L2-L3 stenosis 5) neurogenic glaudication 6) right greater trochanter bursitis 7) degenerative lumbar scoliosis above an L3-S1 fusion.

IMR ISSUES, DECISIONS AND RATIONALES

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

PAIN MANAGEMENT CONSULTATION: Upheld

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

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 Blocks section

Decision rationale: The MTUS does not address the use of SI joint injections. The ODG does not recommend the use of SI joint injections except as a last resort for chronic or severe SI joint pain. Despite the conflicting information in whether a pain management consultation is being made for evaluation and treatment, or whether it is being made specifically for bilateral SI joint injections, there is no evidence to support either one at this point. The injured worker has recently had a pain management consultation, and there is not an explanation of why another consultation is indicated. Additionally, if the request is being made to have the bilateral SI joint injections (which is not entirely clear), the criteria for SI joint injections as outlined by the ODG are not met. The request for pain management consultation is determined to not be medically necessary and appropriate.

L1-2 EPIDURAL STEROID INJECTION: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, CHAPTER EPIDURAL STEROID INJECTIONS, 46

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

Decision rationale: The claims administrator notes that the injured worker has had a previous selective nerve root block (ESI) at the right L1 to nerve roots and the documentation indicated that this provided no benefit. Additionally the claims administrator reports that since an MRI is planned for worsening symptoms, this evaluation should be completed prior to another ESI. Epidural steroid injections are recommended by the MTUS guidelines when the patient's condition meets certain criteria, including radiculopathy being documented by physical exam and corroborated by imaging studies and/or electrodiagnostic testing, and failed conservative treatment. The injured worker has an MRI approved, and this imaging may provide further support for an ESI. At this point though, there is no evidence of at least 50% pain relief with associated reduction in medication use for six to eight weeks following the previous ESI. The request for L1-2 epidural steroid injection is determined to not be medically necessary and appropriate.