

Case Number:	CM14-0011426		
Date Assigned:	02/21/2014	Date of Injury:	12/08/1997
Decision Date:	09/08/2014	UR Denial Date:	01/24/2014
Priority:	Standard	Application Received:	01/28/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Management 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:

This is a female patient with the date of injury of December 8, 1997. It is noted the patient has had extensive PT in the past. A progress report dated January 14, 2014 identifies subjective complaints of flare up neck/back symptoms. The symptoms in low back radiating to buttock, significantly increased, also neck with tension/spasm. The objective findings identify C/S tender/hypertonicity, BPVM upper traps, L/S increased lordosis. Tender BPVM. Left SI positive Faber. The diagnoses identify L/S S/S, LSI sprain, spondylolisthesis L5 on S1, C/S S/S. The treatment plan identifies request PT 3 times a week for 4 weeks for flare up, consultation by the treating physician to redo left SI rhizotomy, and update L/S MRI.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY 3 TIMES A WEEK FOR 4 WEEKS FOR THE LUMBAR SPINE:

Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298, Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 98 OF 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Physical Therapy.

Decision rationale: Regarding the request for physical therapy 3 times a week for 4 weeks for the lumbar spine, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. The ODG has more specific criteria for the ongoing use of physical therapy. The ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. The ODG recommends up to 12 physical therapy sessions. Within the documentation available for review, there is no indication of any objective functional improvement from the therapy already provided, no documentation of specific ongoing objective treatment goals, and no statement indicating why an independent program of home exercise would be insufficient to address any remaining objective deficits. In the absence of such documentation, the current request for physical therapy 3 times a week for 4 weeks for the lumbar spine is not medically necessary.

PAIN MANAGEMENT CONSULTATION: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment.

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 radiofrequency neurotomy American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Occupational Medicine Practice Guidelines, Independent Medical Examinations and Consultations Chapter, Page 127.

Decision rationale: Regarding the request for pain management consultation, the California MTUS does not address this issue. ACOEM supports consultation if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. Specifically regarding sacroiliac joint rhizotomy, the California MTUS does not address the issue. The ODG states that the procedure is not recommended. The use of all of these techniques has been questioned, in part, due to the fact that the innervation of the SI joint remains unclear, and there is also controversy over the correct technique for radiofrequency denervation. They also note that a recent review of this intervention in a journal sponsored by the American Society of Interventional Pain Physicians found that the evidence was limited for this procedure. Within the documentation available for review, consultation is requested to consider possible redo left SI rhizotomy. However, guidelines do not support sacroiliac joint radiofrequency ablation. In light of the above issues, the currently requested pain management consultation is not medically necessary.

ULTRASOUND OF LEFT SI (SACROILIAC) JOINT: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

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, Ultrasound (Sonography).

Decision rationale: Regarding the request for ultrasound of left SI (sacroiliac) joint, the California MTUS does not address this issue. The ODG states the indications for diagnostic ultrasound include scar tissue, adhesions, collagen fiber and muscle spasm, and the need to extend muscle tissue or accelerate the soft tissue healing. Within the documentation available for review, there is no indication that there is scar tissue, adhesions, collagen fiber and muscle spasm, or the need to extend muscle tissue or accelerate the soft tissue healing. In the absence of such documentation, the currently requested ultrasound of left SI (sacroiliac) joint is not medically necessary.

MRI OF THE LUMBAR SPINE: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: OFFICIAL DISABILITY GUIDELINES: Minnesota.

Decision rationale: Regarding repeat imaging, the ODG that repeat imaging of the same views of the same body part with the same imaging modality is not indicated except as follows: to diagnose a suspected fracture or suspected dislocation, to monetary therapy or treatment which is known to result in a change in imaging findings and imaging of these changes are necessary to determine the efficacy of the therapy or treatment, to follow up a surgical procedure, to diagnose a change in the patient's condition marked by new or altered physical findings, to evaluate a new episode of injury or exacerbation which in itself would warrant an imaging study, when the treating healthcare provider and a radiologist from a different practice have reviewed a previous imaging study and agree that it is a technically inadequate study. Within the documentation available for review, it appears the patient has undergone a prior MRI. The requesting physician has not identified a significant change in the patient's subjective complaints or objective findings for which a more recent MRI would be warranted. In the absence of such documentation, the currently requested MRI of the lumbar spine is not medically necessary.