

Case Number:	CM14-0112225		
Date Assigned:	08/01/2014	Date of Injury:	10/01/2012
Decision Date:	09/24/2014	UR Denial Date:	07/15/2014
Priority:	Standard	Application Received:	07/18/2014

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 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:

The injured worker is a 50-year-old male who reported an injury on 10/01/2012. The mechanism of injury was not provided for review. The diagnoses include herniated nucleus pulposus of the lumbar spine with stenosis, lumbar radiculopathy, compression deformity and left SI joint dysfunction. The previous treatments included medication, chiropractic sessions, acupuncture, and surgery. Within the clinical note dated 06/13/2014 it was reported the injured worker complained of low back and left leg pain. The injured worker rated his pain 6 out of 10 in severity. He complained of occasional radiation and numbness and tingling extending from the posterior aspect of the left hip to the posterior aspect of the left knee. Upon the physical examination the provider noted the injured worker had tenderness to palpation over the left SI and the PSIS and the range of motion of the lumbar spine was decreased in all planes. He had intact sensation bilaterally in the lower extremities. Motor strength was 5-/5 and reflexes were within normal limits. He had a negative straight leg raise bilaterally. The provider noted the injured worker had a positive faber, Fortin, Gaenslen's and compression/distraction test on the left. The provider requested sacroiliac joint injections for pain, chiropractic sessions for decreased pain and increase function, Lidopro and Naproxen. The Request for Authorization was submitted on 06/13/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left SI joint injection QTY 1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC, Hip and Pelvis Procedure Summary last updated 3/25/14.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Hip/Pelvis, Sacroiliac Joint Injections.

Decision rationale: The Official Disability Guidelines recommend a sacroiliac joint injection as an option if the injured worker has failed at least 4 to 6 weeks of progressive conservative therapy as indicated. The history and physical should suggest the diagnoses with documentation of at least 3 positive exam findings of specific tests for motion palpation and pain provocation have been described for SI joint dysfunction, including a cranial shear test, extension test, Fortin finger test, Gaenslen's test, Gillet's test, Patrick's test. There is lack of documentation indicating the injured worker failed conservative care for at least 4 to 6 weeks. The guidelines recommend the blocks to be performed under fluoroscopy. The request submitted failed to indicate whether the provider intended the injured worker to have fluoroscopy with the injection. There is lack of documentation indicating the injured worker had sacroiliac joint tenderness on examination and lack of limited clinical findings consistent with sacroiliac joint dysfunction. The request is not medically necessary.

LidoPro topical ointment 4 oz QTY 1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSAIDs Page(s): 111-112.

Decision rationale: The California MTUS Guidelines states topical NSAIDs are recommended for osteoarthritis and tendinitis, in particular, that of knee and/or elbow and other joints that are amenable. Topical NSAIDs are recommended for a short time use of 4 to 12 weeks. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the treatment site and the frequency. The injured worker has been utilizing the medication since at least 01/2014, which exceeds the guideline's recommendation of short term use of 4 to 12 weeks. The request is not medically necessary.

Naproxen sodium 550 mg QTY 60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Naproxen, NSAIDs (non-steroidal anti-inflammatory drugs), p Page(s): 66-67.

Decision rationale: The California MTUS Guidelines note naproxen is a non-steroidal anti-inflammatory drug for the relief of the signs and symptoms of osteoarthritis. The guidelines recommend that the lowest dose for the shortest period of time in patients with moderate to severe pain. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The injured worker has been utilizing the medication since at least 01/2014. There is a lack of documentation indicating the frequency of the medication. The request is not medically necessary.

Chiropractic therapy, once weekly for 8 weeks QTY 8: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation. Decision based on Non-MTUS Citation ODG.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58.

Decision rationale: The California MTUS Guidelines recommend that manual therapy for chronic pain if caused by musculoskeletal conditions. The intended goal or effect of manual therapy is the achievement of positive symptomatic or objective measurable gains in functional improvement and facilitate progression in the patient's therapeutic exercise program and return to productive activities. The guidelines recommend a trial of 6 visits over 2 weeks, and with evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks. There is a lack of documentation indicating the injured worker had significant objective functional improvement with a prior course of therapy. There is a lack of documentation regarding a complete physical exam to evaluate the decreased functional ability, decreased strength or flexibility. The injured worker has utilized 9 sessions of chiropractic therapy; however, there is lack of documentation indicating the efficacy of the therapy. The request is not medically necessary