

Case Number:	CM14-0130656		
Date Assigned:	08/20/2014	Date of Injury:	01/14/2014
Decision Date:	09/23/2014	UR Denial Date:	08/01/2014
Priority:	Standard	Application Received:	08/15/2014

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 Nevada. 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 42 year-old female who was reportedly injured on 1/14/2014. The mechanism of injury is not listed. The most recent progress note, dated 7/28/2014. Indicates that there are ongoing complaints of low back pain, like pain, and neck pain. The physical examination demonstrated lumbar spine: decrease mobility with pain, posterior tenderness to palpation left L4-S-1. Positive tenderness to palpation left PSIS and greater trochanteric bursa. Bilateral lower extremity reflexes 2/4. Muscle strength 5/5. Diagnostic imaging studies magnetic resonance image of the lumbar spine dated 3/4/2014 reveals disk bulge at L5-S-1, mild foraminal exit zone compromise. Facet joint hypertrophy bilaterally. Previous treatment includes medications, and physical therapy. A request had been made for lumbar epidural steroid injection at L5-S-1, left PSIS, and steroid injection at left greater trochanteric bursa, and was not certified in the pre-authorization process on 8/1/2014.11217

IMR ISSUES, DECISIONS AND RATIONALES

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

L5-S1 Lumbar Interlaminar Injection, ESI (Epidural Steroid Injection): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS; (Effective July 18, 2009) Page(s): 46 of 127.

Decision rationale: California Medical Treatment Utilization Schedule (CAMTUS) guidelines support epidural steroid injections when radiculopathy is documented on physical examination and corroborated by imaging and electrodiagnostic studies in individuals who have not improved with conservative care. Based on the clinical documentation provided, and considering the criteria for the use of epidural steroid injections as outlined in the CAMTUS; there is insufficient clinical evidence presented that the proposed procedure meets the CAMTUS guidelines. Specifically, there is no documentation of radiculopathy on physical exam. As such, the requested procedure is deemed not medically necessary.

Left PSIS (Posterior Superior Iliac spine) Injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

Decision rationale: California Treatment Guidelines do not support sacroiliac (SI) joint injections for acute, subacute, or chronic low back pain. The only clinical indication for an SI joint injection is for therapeutic treatment for specific inflammatory disorders such as rheumatoid arthritis. When noting that the guidelines do not support SI joint injection for the diagnosis noted, this request is deemed not medically necessary.

Left GTB (Greater Trochanteric Bursa) Injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 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 (Acute and Chronic). Steroid Injection (Trochanteric Bursitis). Updated 3/25/2014.

Decision rationale: Official Disability Guidelines guidelines state trochanteric bursitis injections are recommended. For a trochanteric pain, corticosteroid injection is safe and highly effective, with a single cortisone injection often providing satisfactory pain relief. After review the medical documentation provided it is noted the injured worker does have significant low back and gluteal pain, but is limited documentation for tenderness to palpation of the greater trochanteric bursa. Therefore this request is deemed not medically necessary.