

Case Number:	CM14-0154290		
Date Assigned:	09/23/2014	Date of Injury:	03/15/2013
Decision Date:	10/24/2014	UR Denial Date:	08/26/2014
Priority:	Standard	Application Received:	09/22/2014

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 Illinois. 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 49-year-old who reported an injury on March 15, 2013. The mechanism of injury was not provided. Diagnoses included lumbosacral sprain/strain, right sacroiliac joint arthropathy, right shoulder pain, and right knee pain secondary to osteoarthritis. Past treatments included Synvisc injection to the right knee and medications. Pertinent diagnostic studies were not provided. Surgical history was not provided. The clinical note dated March 27, 2014 indicated the injured worker complained of right knee, right shoulder, and low back pain. Physical exam revealed positive straight leg raise and positive FABER test on the right. The physician also noted tenderness to palpation on the medial and lateral side of the right knee, medial border of the patella, and pain with range of motion and crepitation for the right knee. Current medications included meloxicam, omeprazole 20 mg, compounded flurbiprofen/cyclobenzaprine cream, and tizanidine 4 mg. The treatment plan included the purchase of a motorized cold therapy unit and tizanidine 4 mg 2 tablets every night #60. The rationale for the motorized cold therapy unit was not provided. The rationale for tizanidine was for muscle relaxation. The request for authorization form was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Motorized cold therapy unit (purchase): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disabilities Guidelines (ODG), Low Back Chapter, cold/heat pack section

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 337.

Decision rationale: The Knee Complaints Chapter of the ACOEM Practice Guidelines recommend at home local application of cold packs in the first few days of acute shoulder, low back, and knee complaints. The injured worker complained of right knee, right shoulder, and low back pain. As her injury reportedly occurred on March 15, 2013, she is being treated for chronic pain and has exceeded the acute phase of symptom relief. Additionally, there is no evidence of a trial of a motorized cold therapy unit or to indicate the need of a motorized unit over traditional cold packs. As the guidelines only recommend cold packs in the acute phase of symptom relief, the request cannot be supported at this time. Therefore, the request for the purchase of a motorized cold therapy unit is not medically necessary or appropriate.

Tizanidine 4 mg, sixty count: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity/Antispasmodic drugs, Tizanidine (Zanaflex , gener.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain), Page(s): 63.

Decision rationale: The Chronic Pain Medical Treatment Guidelines recommend nonsedating muscle relaxants with caution as a second line option for short term treatment of acute exacerbations in patients with chronic low back pain; however, in most low back pain cases, they show no benefit beyond NSAIDs (non-steroidal anti-inflammatory drugs) in pain and overall improvement. The injured worker complained of pain in the right knee, right shoulder, and low back. She had been taking the requested medication since at least November 7, 2013. There is a lack of clinical documentation to indicate the efficacy of the requested medication, including functional improvement and quantified pain relief. Additionally, the guidelines recommend muscle relaxants only as a short term treatment. Therefore, the request for Tizanidine 4 mg, sixty count, is not medically necessary or appropriate.

Right sacroiliac joint steroid injection under fluoroscopy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disabilities Guidelines (ODG), Hip and Pelvis Chapter, Sacroiliac joint blocks

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip, Sacroiliac joint blocks

Decision rationale: The Official Disability Guidelines indicate the criteria for the use of sacroiliac blocks includes history and physical suggestive of the diagnosis with documentation of at least 3 provocative exam findings, diagnostic evaluation must first address any other possible pain generators, and the patient has had an failed at least 4 to 6 weeks of aggressive conservative therapy including physical therapy, home exercise, and medication management. The clinical note dated March 27, 2104 did not indicate that the patient complained of right hip pain, but the physician noted a right positive FABER test. While the FABER test is a specific test for motion palpation and pain provocation for sacroiliac joint dysfunction, the guidelines indicate that documentation must include at least 3 positive exam findings. Additionally, there is a lack of evaluation of diagnostic studies or evidence that the injured worker recently completed an aggressive course of conservative therapy including physical therapy and home exercise. Therefore, the request for right sacroiliac joint steroid injection under fluoroscopy is not medically necessary or appropriate.