

Case Number:	CM14-0030576		
Date Assigned:	06/20/2014	Date of Injury:	12/06/2008
Decision Date:	07/17/2014	UR Denial Date:	02/26/2014
Priority:	Standard	Application Received:	03/10/2014

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 Medicine and is licensed to practice in Texas. 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 34 year old male who sustained an injury to his low back on 12/06/08. The mechanism of injury was not documented. The records indicate that the injured worker is status post L4-5 and L5-S1 anterior lumbar interbody fusion (ALIF) dated 02/06/13. The injured worker has been experiencing discomfort in the abdomen, with a sensation of burning and tenderness that is now localized to the upper/lower left quadrant left of the incision. Physical examination noted tenderness along the left lower quadrant immediately left centers; 5-/5 muscle strength of the thoracolumbar musculature with flexion and extension; antalgic gait; pain 5/10. Treatment to date has included medications and physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

S1 Joint injections under fluoroscopic guidance: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines; Work Loss Data Institute, LLC; Corpus Christi, Tx; www.odg-twc.com; Section: Low Back.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Sacroiliac Joint Injections Page(s): 345.

Decision rationale: The request for sacroiliac joint injections under fluoroscopic guidance is not medically necessary. The laterality and amount of injections was not specified in the request. The previous request was denied on the basis that the only clinical indication for an sacroiliac joint injection is for therapeutic treatment for a specific inflammatory disorder such as rheumatoid arthritis. The documentation provided did not indicate any evidence of rheumatoid arthritis or any other inflammatory arthropathy. Given this, there was no clinical indication for the request for sacroiliac (S1) joint injections under fluoroscopic guidance and the request is not indicated as medically necessary.