

Case Number:	CM14-0039073		
Date Assigned:	06/27/2014	Date of Injury:	03/18/2011
Decision Date:	07/28/2014	UR Denial Date:	03/26/2014
Priority:	Standard	Application Received:	04/03/2014

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 Georgia and Wisconsin. 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 patient is a 43 year old female who was injured on 03/18/2011. She sustained an injury to her wrist. She has had multiple falls and developed left sided knee pain and right sided back pain. On neuro consult dated 03/06/2014, the patient complained of right sided back pain, right groin and hip pain, numbness and tingling in the right leg. She rated her pain as a 4/10. She also gets a numbing tingling sensation radiating to the right leg in the L3-L4 distribution. Her exam was within normal limits. Progress note dated 02/24/2014 states the patient complains of low back pain radiating to the right lower extremity. On exam, gait is normal. She is tender at the L4 level and over right paraspinal muscles. Her diagnosis is lumbar spine sprain. Prior utilization review dated 03/26/2014 states the request for physical therapy 2-3 x 6-8 weeks for the low back is not authorized but has been modified to physical therapy for 6 sessions. The request for Right L4-5 and L5-S1 Facet Injection is not certified as there is a lack of documentation providing evidence of failed first line treatments. The request for Right SI Joint Injection is not authorized as there is limited evidence of the patient's symptomatology rising from SI joint problems.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 2-3 x 6-8 weeks for the low back: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98.

Decision rationale: The Chronic Pain Medical Treatment guidelines recommend for myalgia and myositis, unspecified: 9-10 visits over 8 weeks and for neuralgia, neuritis, and radiculitis, unspecified 8-10 visits over 4 weeks. The medical records provided did not document objective improvement with previous treatment, functional deficits and functional goals, and a statement when the patient would be independent with a home exercise program. Based on the Chronic Pain Medical Treatment guidelines and criteria as well as the clinical documentation stated above, the request is not medically necessary.

Right L4-5 and L5-S1 Facet Injection: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 167-175.

Decision rationale: The ACOEM and ODG do not recommend Facet Injection for low back pain with radicular symptoms. Medical records provided lack clear documentation of failed treatment with first line of modalities. The patient also appears to have radicular symptoms that are not corroborated by diagnostic studies. Based on the ACOEM and ODG as well as the clinical documentation stated above, the request is not medically necessary.

Right SI Joint Injection: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 167-175.

Decision rationale: The ACOEM recommends Sacroiliac joint corticosteroid injections as a treatment option for patients with a specific known cause of sacroiliitis, i.e., proven rheumatologic inflammatory arthritis involving the sacroiliac joints. The medical records provided do not indicate that patient's symptomatology rising from SI joint problems. There is also lack of documentation to show failure of first line therapy towards SI joint. Based on the ACOEM guidelines and criteria as well as the clinical documentation stated above, the request is not medically necessary.