

Case Number:	CM14-0070829		
Date Assigned:	07/14/2014	Date of Injury:	08/21/2012
Decision Date:	08/22/2014	UR Denial Date:	04/25/2014
Priority:	Standard	Application Received:	05/16/2014

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 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 57-year-old female who reported an injury on 08/21/2012. The mechanism of injury was not provided for clinical review. The diagnoses included left sacroiliitis, cervical pain, left shoulder pain, and left knee pain. Previous treatments included sacroiliac injection, medication, physical therapy, and MRI. Within the clinical note dated 03/24/2014, it was reported the injured worker complained of left sacroiliac pain. The rated her pain 6/10 in severity. Within the physical examination, the provider noted tenderness of the left sacroiliac joint. The injured worker had a positive Patrick's test. The provider noted tenderness of the left shoulder diffusely, with limited range of motion. The injured worker had decreased spasms of the lumbar paraspinal musculature. The provider requested for continuation of physical therapy for the sacroiliac joint, left, to include lumbar spine at 3 times per week for 4 weeks; second and third sacroiliac joint injection, first injection did facilitate diminution and pain and improved tolerance to a variety of activity; EMG/NCV of the bilateral upper extremities; and cyclobenzaprine. The Request for Authorization was submitted and dated on 04/16/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 3 x 4 weeks for Low Back: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 114. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine, page(s) 98-99 Page(s): 98-99.

Decision rationale: The request for physical therapy 3 times a week for 4 weeks for the low back is non-certified. The injured worker complained of left sacroiliac pain. She rated her pain 6/10 in severity. California MTUS Guidelines that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, and range of motion. The guidelines allow for fading of treatment frequency, plus active self-directed home physical medicine. The guidelines note for neuralgia and myalgia, 8 to 10 visits of physical therapy are recommended. There is a lack of documentation indicating the injured worker's prior course of physical therapy, as well as the efficacy of the prior therapy. The request submitted is for 12 sessions of physical therapy, which exceeds the guidelines' recommendations of 8 to 10 visits of physical therapy. There is a lack of documentation, including an adequate and complete physical examination demonstrating the injured worker had decreased functional ability, decreased range of motion, and decreased strength or flexibility. Therefore, the request is non-certified.

EMG Bilateral Upper Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 238. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck, and Upper Back Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268-269.

Decision rationale: The request for EMG of the bilateral upper extremities is non-certified. The injured worker complained of left sacroiliac pain. She rated her pain 6/10 in severity. The California MTUS/ACOEM Guidelines recommend an electromyography in cases of peripheral nerve impingement. If no improvement or worsening has occurred within 4 to 6 weeks, electrical studies may be indicated. There is a lack of documentation indicating muscle weakness and numbness symptoms that would indicate peripheral nerve. There is lack of significant neurological deficits such as decreased sensation, decreased strength. Although the left shoulder may warrant an EMG, there is a lack of documentation indicating right shoulder signs and symptoms requiring an EMG. Therefore, the request is non-certified.

NCV of the Bilateral Upper Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 238. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck, and Upper Back Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268-269.

Decision rationale: The request for an NCV of the bilateral upper extremities is non-certified. The injured worker complained of left sacroiliac pain. She rated her pain 6/10 in severity. The California MTUS/American College of Occupational and Environmental Medicine, in nerve conduction for patients presenting with true hand and wrist problems, special studies are not needed until a 4 to 6 week period of conservative care and observation. Most patients improve quickly, provided red flag conditions are ruled out. NCV studies are recommended to diagnose carpal tunnel syndrome. There is lack of significant neurological deficits such as decreased sensation, decreased strength. There is a lack of documentation indicating red flag conditions. The injured worker was not treated for or diagnosed with carpal tunnel syndrome. There is a lack of documentation indicating the injured worker has undergone a 4 to 6 week period of conservative care and observation. Therefore, the request is non-certified.

Second and Third Sacroiliac Joint Injection: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG Hip/Pelvis SI.

Decision rationale: The request for a second and third sacroiliac joint injection is non-certified. The injured worker complained of left sacroiliac pain. She rated her pain 6/10 in severity for the left shoulder. The Official Disability Guidelines recommend a sacroiliac joint injection as an option of the injured worker has failed at least 4 to 6 weeks of aggressive conservative therapy, as indicated below. The history and physical should suggest the diagnosis with documentation of at least 3 positive exam findings of specific tests for motion palpation and pain provocation have been described for sacroiliac joint dysfunction. Cranial shear test, extension test, flamingo test, Fortin finger test, Gaenslen's test, Gillett's test, pelvic compression test. There is a lack of objective findings indicating the injured worker had sacroiliac joint dysfunction. Additionally, there is a lack of documentation of conservative care which was tried and failed. Therefore, the requests for second and third sacroiliac joint injections are non-certified.

Cyclobenzaprine 7.5mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63, 64.

Decision rationale: The request for cyclobenzaprine 7.5 mg #90 is non-certified. The injured worker complained of left sacroiliac pain. She rated her pain 6/10 in severity. The injured worker complained of shoulder pain, which she rated 6/10 in severity. The California MTUS Guidelines recommend non-sedating muscle relaxants with caution as a second-line option for

short-term treatment of acute exacerbation in patients with chronic low back pain. The guidelines note the medication is not recommended to be used for longer than 2 to 3 weeks. Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most low back pain cases, they show no benefit beyond NSAIDs in pain and overall improvement. There is a lack of objective indicating the injured worker was treated for or diagnosed with muscle spasms. The injured worker had been utilizing the medication for an extended period of time, since at least 03/2014, which exceeds the guidelines' recommendation of short term use of 2 to 3 weeks. There is a lack of documentation indicating the efficacy of the medication, as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Therefore, the request is non-certified.