

Case Number:	CM15-0149584		
Date Assigned:	08/14/2015	Date of Injury:	08/15/2008
Decision Date:	09/11/2015	UR Denial Date:	07/14/2015
Priority:	Standard	Application Received:	08/01/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: New Jersey, Alabama, California
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 57 year old woman sustained an industrial injury on 8-15-2006. The mechanism of injury is not detailed. Diagnoses include status post failed right hip surgery, low back condition with multilevel degenerative changes with aggravation after surgery, gait disturbance and left hip overloading with pain and weakness, bilateral shoulder impingement syndrome, left knee overloading and use of cane with aggravation, bilateral wrist degenerative joint disease, situational reactive depression due to chronic pain, bilateral carpal tunnel syndrome, cervical spine muscle spasm and chronic pain, and migraine headaches aggravated by cervical condition. Treatment has included oral medications and physical therapy. Physician notes from the QME dated 5-26-2015 show complaints of neck pain, headaches, bilateral hand and wrist pain, and low back pain. Recommendations include continue current medications regimen and follow up in one week.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left sacroiliac joint ligament injection: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Low Back, Sacroiliac blocks.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Sacroiliac injections.

Decision rationale: MTUS guidelines are silent regarding sacroiliac injections. According to ODG guidelines, sacroiliac injections are medically necessary if the patient fulfills the following criteria: 1.the history and physical examination should suggest the diagnosis; 2. Other pain generators should be excluded; 3. Documentation of failure of 4-6 weeks aggressive therapies; 4. Blocks are performed under fluoroscopy; 5. Documentation of 80% pain relief for a diagnostic block; 6. If steroids are injected during the initial injection, the duration of relief should be at least 6 weeks; 7. In the therapeutic phase, the interval between 2 block is at least 2 months; 8. The block is not performed at the same day as an epidural injection; 9. The therapeutic procedure should be repeated as needed with no more than 4 procedures per year. It is not clear from the patient's file, that the patient fulfills the criteria of sacroiliac damage that the sacroiliac joint is the pain generator and other pain generators have been excluded. Therefore, the requested for Left sacroiliac joint ligament injection is not medically necessary.

Thoracic lumbo sacral orthosis with anterior and posterior lateral stabilization: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

Decision rationale: According to MTUS guidelines, lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. A lumbar corset is recommended for prevention and not for treatment. There is no evidence of acute spine fracture or instability. Therefore, the request for Thoracic lumbo sacral orthosis with anterior and posterior lateral stabilization is not medically necessary.

Follow up visit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 341.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain programs, early intervention Page(s): 32-33.

Decision rationale: According to MTUS guidelines, the presence of red flags may indicate the need for specialty consultation. In addition, the requesting physician should provide a documentation supporting the medical necessity for a pain management evaluation with a specialist. The documentation should include the reasons, the specific goals and end point for using the expertise of a specialist. In this case, there is no clear documentation for the rational for the request for a follow-up visit. The requesting physician did not provide a documentation supporting the medical necessity for this visit. The provider documentation should include the reasons, the specific goals and end point for using the expertise of a specialist. Therefore, the request for follow-up is not medically necessary.