

Case Number:	CM15-0217459		
Date Assigned:	11/09/2015	Date of Injury:	05/24/2000
Decision Date:	12/29/2015	UR Denial Date:	10/06/2015
Priority:	Standard	Application Received:	11/04/2015

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: California, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, Pain Management

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 65 year old female, who sustained an industrial injury on 5-24-2000. According to physician documentation, the injured worker was diagnosed with chronic cervical radiculopathy, cervical degenerative disc disease, cervical degenerative joint disease and sciatica/piriformis syndrome. Physician documentation dated 6-30-2015, states since the injury, the worker continued to experience moderate persistent low back pain radiating down the left leg with some constricted muscular spasms that worsen with repetitive bending. Subjective findings dated 9-21-2015, were notable for no new acute complaints denying any new neurological abnormalities. She currently describes localized pain in her neck that is aggravated with any kind of repetitive upper extremity activity, rating pain 6 out of 10. However, she continues to work full-time duty. Objective findings dated 6-30-2015, were notable for lumbar extension of 15 degrees, local palpatory tenderness and muscular spasm in the lower lumbar paravertebral muscles, taut muscular band palpated in the left piriformis and sciatic notch and increased pain with mild straight leg rise. Treatment to date have included physical therapy, Vicodin 7.5/300mg, Cyclobenzaprine 10mg, Celebrex 200mg, Lidocaine patch 5%, and Ambien 10mg(since 12-9-2014), Biofreeze, Kinesio tape, and the use of a TENS (Transcutaneous Electrical Nerve Stimulation) unit which has been beneficial to her. The Utilization Review determination dated 10-6-2015 did not certify retrospective treatment/service requested for Piriformis muscle injection qty. 1.

IMR ISSUES, DECISIONS AND RATIONALES

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

Piriformis muscle injection times 1: Upheld

Claims Administrator guideline: Decision based on MTUS General Approaches 2004, Section(s): Initial Approaches to Treatment, and Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Low back chapter and Hip chapter.

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

Decision rationale: The MTUS guidelines are silent on piriformis block. Per the ODG guidelines "Recommended for piriformis syndrome after a one-month physical therapy trial. Piriformis syndrome is a common cause of low back pain and accounts for 6-8% of patients presenting with buttock pain, which may variably be associated with sciatica, due to a compression of the sciatic nerve by the piriformis muscle (behind the hip joint). Piriformis syndrome is primarily caused by fall injury, but other causes are possible, including pyomyositis, dystonia musculorum deformans, and fibrosis after deep injections. Symptoms include buttock pain and tenderness with or without electrodiagnostic or neurologic signs. Pain is exacerbated in prolonged sitting. Specific physical findings are tenderness in the sciatic notch and buttock pain in flexion, adduction, and internal rotation (FADIR) of the hip. Imaging modalities are rarely helpful, but electrophysiologic studies should confirm the diagnosis, if not immediately, then certainly in a patient re-evaluation and as such should be sought persistently. Physical therapy aims at stretching the muscle and reducing the vicious cycle of pain and spasm. It is a mainstay of conservative treatment, usually enhanced by local injections. Surgery should be reserved as a last resort in case of failure of all conservative modalities. No consensus exists on overall treatment of piriformis syndrome due to lack of objective clinical trials." The documentation submitted for review did not indicate that a physical therapy trial for this current exacerbation of pain has occurred. As the criteria is not met, the request is not medically necessary.