

Case Number:	CM15-0038422		
Date Assigned:	03/09/2015	Date of Injury:	08/11/2000
Decision Date:	05/12/2015	UR Denial Date:	02/13/2015
Priority:	Standard	Application Received:	03/02/2015

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

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 was noted to have a date of injury of 09/11/2000. The date of birth was not provided. The mechanism of injury and surgical history were not provided. The specific medications were not provided. The documentation of 12/05/2014 revealed the injured worker had continual pain in the low back with some radiation into the buttocks and thighs. The injured worker was noted to have focal tenderness throughout the left SI joint. Pelvic compression test referred pain immediately into the left sacroiliac area. The straight leg raise test on the left produced SI pain, and on the right, reproduced some back pain only. The sensory examination was within normal limits. The motor examination was normal in all major muscle groups. The quadriceps reflexes were 1 to 2+ and symmetrical. The Achilles reflexes were 0 to 1+ and symmetrical. There were no pathologic reflexes evident. The range of motion was full bilaterally. There was no groin or thigh pain. The injured worker was provided with medications to maintain his status. The injured worker was advised to have an injection of his left sacroiliac joint under ultrasound for diagnostic and therapeutic reasons. There was no Request for Authorization submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Ultrasonic guided major joint injection, back (DOS: 12/5/14): Upheld

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

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 Chapter Sacroiliac joint blocks.

Decision rationale: The Official Disability Guidelines recommends sacroiliac joint blocks when the history and physical should suggest the diagnosis with documentation of at least 3 positive exam findings including the Cranial Shear Test; Extension Test; Flamingo Test; Fortin Finger Test; Gaenslen's Test; Gillet's Test (One Legged-Stork Test); Patrick's Test (FABER); Pelvic Compression Test; Pelvic Distraction Test; Pelvic Rock Test; Resisted Abduction Test (REAB); Sacroiliac Shear Test; Standing Flexion Test; Seated Flexion Test; Thigh Thrust Test (POSH). The diagnostic evaluation must first address any other possible pain generators and there should be documentation that the injured worker has had and failed at least 4-6 weeks of aggressive conservative therapy including Physical therapy, home exercise and medication management. Blocks are performed under fluoroscopy. The clinical documentation submitted for review indicated the injured worker had a positive pelvic compression test. However, there was a lack of documentation of 2 other positive examination findings. There was a lack of documentation indicating that other possible pain generators had been evaluated. Additionally, there was a lack of documentation of a failure of 4 to 6 weeks of aggressive conservative therapy including physical therapy and home exercise and medication management. The request as submitted failed to indicate the specific injection and joint to be injected. Given the above, request for Retrospective request for ultrasonic guided major joint injection, back for 12/5/14 is not medically necessary.

Retrospective Tramadol/acetaminophen 37.5/325mg QTY: 180 (DOS: 12/5/14): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, ongoing management Page(s): 60, 78.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend opiates for the treatment of chronic pain. There should be documentation of objective functional improvement, an objective decrease in pain and documentation the injured worker has been monitored for aberrant drug behavior and side effects. The cumulative dosing of all opiates should not exceed 120 mg of oral morphine equivalents per day. The injured worker was utilizing 2 medications which would total 125 mg of daily morphine equivalent dosing. There was a lack of documentation of objective functional improvement, an objective decrease in pain and documentation the injured worker was being monitored for aberrant drug behavior and side effects. The frequency was not provided for the submitted request. Given the above, the request for retrospective request for Tramadol/acetaminophen 37.5/325 mg QTY: 180 for 12/5/14 is not medically necessary.

Retrospective Omeprazole 20 mg QTY: 180 (DOS: 12/5/14): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 69.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines state proton pump inhibitors are recommended for injured workers at intermediate or high risk for gastrointestinal events. Injured workers with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor. The injured worker was not noted to be at intermediate or high risk for gastrointestinal events. Therefore, the injured worker does not currently meet criteria for the requested medication. The clinical documentation submitted for review failed to provide documentation exceptional factors to warrant nonadherence to guideline recommendations. The frequency for the requested medication was not provided. There was a lack of documentation indicating the injured worker had gastric upset. Given the above, the request for Retrospective request for Omeprazole 20 mg QTY: 180 for 12/5/14 is not medically necessary.

Retrospective Hydrocodone/Ibuprofen 7.5/200mg QTY: 240 (DOS: 12/5/14): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, ongoing management Page(s): 60, 78.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend opiates for the treatment of chronic pain. There should be documentation of objective functional improvement, an objective decrease in pain and documentation the injured worker has been monitored for aberrant drug behavior and side effects. The cumulative dosing of all opiates should not exceed 120 mg of oral morphine equivalents per day. The injured worker was utilizing 2 medications which would total 125 mg of daily morphine equivalent dosing. There was a lack of documentation of objective functional improvement, an objective decrease in pain and documentation the injured worker was being monitored for aberrant drug behavior and side effects. The frequency was not provided for the submitted request. Given the above, the request for Retrospective request for Hydrocodone/Ibuprofen 7.5/200 QTY: 240 for 12/5/14 is not medically necessary.