

Case Number:	CM14-0145954		
Date Assigned:	09/12/2014	Date of Injury:	09/07/2011
Decision Date:	10/16/2014	UR Denial Date:	08/21/2014
Priority:	Standard	Application Received:	09/08/2014

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 Texas. 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 40-year-old female who reported an injury on 09/07/2011. The mechanism of injury was not provided. On 08/29/2014, the injured worker presented with lumbar spine pain. Past surgical history included a lumbar anterior posterior L5-S1 PLIF on 03/12/2013. Treatment included physical therapy, heat treatment and ice treatment. Upon examination there was 5/5 motor strength in the upper extremities throughout. There are 2+ deep tendon reflexes in the biceps, triceps, and brachioradialis bilaterally. Examination of the lumbar spine noted tenderness to palpation over the left lumbar facets, and lumbar spasm of the left sacroiliac joint, left buttock, left lumbosacral region, left lateral hip. There was a positive straight leg raise to the left. Hip flexion noted 5/5 strength in the right and 4/5 strength to the left. There is left lower extremity mild improvement with improved nerve tension signs and strength post epidural steroid injection. The diagnoses were sacroiliitis, lumbar disc displacement with myelopathy, lumbar disc displacement, lumbosacral neuritis not otherwise specified. The provider recommended a left sacroiliac joint injection and the purchase of a 1 year gym membership. The provider's rationale was not provided. The Request for Authorization form was not included in the medical documents for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Sacroiliac 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, Hip & Pelvis Chapter, Sacroiliac Joint Blocks

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

Decision rationale: The request for a left sacroiliac joint injection is not medically necessary. The Official Disability Guidelines state that sacroiliac joint injections are recommended as an option if 4 to 6 weeks of aggressive conservative therapy had failed. The criteria for use of a sacroiliac block include a history and physical suggesting a diagnosis, diagnostic evaluation must first address any other possible pain generators, a failure of at least 4 to 6 weeks of aggressive conservative therapy and the use of fluoroscopy for guidance with the use of the injections. The documentation submitted for review revealed tenderness over the left sacroiliac joint. There is lack of documentation of specific tests performed that address sacroiliac joint dysfunction to include extension test, flamingo test, Fortin finger test, Gaenslen test, Galant test, pelvic compression test, pelvic distraction test, and resisted abduction test. The physical examination noted a positive left sided FABERE's test. There must be documentation of at least 3 positive exam findings of SI joint dysfunction. There is also lack of at least 4 to 6 weeks of aggressive conservative therapy to include physical therapy, home exercise, and medication management. As such, medical necessity has not been established.

Purchase of a (1) Year Gym Membership: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Exercise. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter, Gym Memberships

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Gym

Decision rationale: The request for a 1 year gym membership is not medically necessary. The Official Disability Guidelines recommend exercise as a part of a dynamic rehabilitation program, but note that gym membership is not recommended as a medical prescription unless a home exercise program has not been effective, and there is a need for equipment. Exercise treatment needs to be monitored and administered by medical professionals. There is no documentation of failed home exercise or the injured worker's need for specific equipment that would support the medical necessity for a gym membership. As such, medical necessity has not been established.