

Case Number:	CM14-0163159		
Date Assigned:	10/08/2014	Date of Injury:	12/27/2013
Decision Date:	11/07/2014	UR Denial Date:	09/03/2014
Priority:	Standard	Application Received:	10/03/2014

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 Occupational 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:

This case involves a 52 year-old male with date of injury 12/27/2013. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 08/04/2014, lists subjective complaints as constant low back pain. MRI of the lumbar spine performed on 01/23/2014 was notable for 1-2mm of annular disc bulging at L2-3; 2mm of annular disc bulging eccentric to the left with mild to moderate facet arthropathy at L4-5; and mild broad-based disc bulging most pronounced centrally where there was 2.5mm of posterior extension at L5-S1. The objective findings include the examination of the lumbar spine which revealed tenderness to palpation of the paravertebral muscles from L2-S1 with no spasm. Tenderness was noted over the left sacroiliac joint. No sacrococcygeal tenderness. Range of motion was restricted in all planes. Straight leg raising test was positive on the left in both the sitting and the supine position at 60 degrees. Deep tendon reflexes were 2+/4 bilaterally for the Achilles reflexes. Partrick Fabere test was negative bilaterally. Motor strength of lower extremities was 5/5 on the right and 4/5 on the left. Decreased sensation was noted over the lateral aspect of the left leg. Peripheral pulses were 2+/4 and equal bilaterally. The current diagnosis includes low back pain; lumbar strain/sprain; radiculitis of left lower extremity; and probable herniated nucleus pulposus L4-5 and L5-S1.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percutaneous neurostimulator 1 x 4 weeks lumbar: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Percutaneous Electrical Nerve Stimulation (PENS)

Decision rationale: The Official Disability Guidelines (ODG) do not recommend percutaneous electrical nerve stimulation has a primary treatment modality, but a trial may be considered, if used as an adjunct to a program of evidence-based functional restoration. However, after other non-surgical treatments, including therapeutic exercise and TENS, have been tried and failed or are judged to be unsuitable or contraindicated. There is a lack of high quality evidence to prove long-term efficacy. Percutaneous neurostimulator 1 x 4 weeks lumbar is not medically necessary.

Left SI joint injection under fluoroscopic guidance: 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) Chapter Pain

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Guidelines (ODG) Hip & Pelvis (Acute & Chronic), Sacroiliac joint blocks

Decision rationale: The Official Disability Guidelines (ODG) state that there is limited research suggesting therapeutic blocks offer long-term effect. There should be evidence of a trial of aggressive conservative treatment (at least six weeks of a comprehensive exercise program, local icing, mobilization/manipulation and anti-inflammatories) as well as evidence of a clinical picture that is suggestive of sacroiliac injury and/or disease prior to a first SI joint block. Some ODG criteria for the use of sacroiliac blocks include: 1. The history and physical should suggest the diagnosis with documentation of at least 3 positive exam findings, 2. Diagnostic evaluation must first address any other possible pain generators, and 3. The patient has had and failed at least 4-6 weeks of aggressive conservative therapy, including physical therapy, home exercise and medication management. The available documentation fails to meet the criteria needed to recommend an SI joint block. Therefore, the left SI Joint injection under fluoroscopic guidance is not medically necessary.