MAXIMUS Federal Services

Case Number:	CM14-0165760		
Date Assigned:	10/10/2014	Date of Injury:	08/13/2012
Decision Date:	11/12/2014	UR Denial Date:	09/19/2014
Priority:	Standard	Application Received:	10/08/2014

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 Emergency 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:

Patient has a date of injury on 8/13/2012. Mechanism of injury is described as was carrying a heavy load when trip and injured back. Patient has a diagnosis of lumbosacral strain and sacroiliac joint sprain/strain.Medical reports reviewed. Last report available until 8/13/14. Patient complains of low back pain. Pain is right (R) low back and is 4-7/10. No associated symptoms.Objective exam reveals mild antalgic gait, decreased R hip motion with pain, moderate-severe pain at R sacroiliac (SI) joint, spasms in R Piriformis with tenderness to paraspinal and limited motion due to pain. Patient had reported SI joint injection on 2/11/13 and 8/12/13. There is report of no improvement with the SI joint injection on note dated 8/15/13.MRI of lumbar spine (12/4/13) revealed L5-S1 slight protrusion and Schmorl's node inferior L3 at 5x7mm.Medications include Qvar, Omeprazole, Fluoxetine, Trazadone and Fluticasone.Patient has reportedly received physical therapy, SI joint injection and medications.Independent Medical Review is for R SI joint cortisone injection under ultrasound, R Piriformis injection under ultrasound, prednisone 10mg #37 and Tizanidine 4mg #60 with 2refills.Prior UR on 9/19/14 recommended non-certification.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cortisone injection to right SI joint ligament under ultrasound guidance: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines: Hip & Pelvis 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 and Pelvis, Sacroiliac Joint Blocks

Decision rationale: MTUS Chronic pain and ACOEM guidelines do not have any sections that deal with this topic. Official Disability Guidelines (ODG) recommend Sacroiliac (SI) joint blocks under certain guidelines: 1) 3 positive findings consistent with SI joint dysfunction. Fails criteria.2) Diagnostic evaluation must address other pain generators. Does not meet criteria. Patient has lumbar pathology that is being treated. Lumbar pain may be primary source of pain and it has not yet been appropriately dealt with.3) Aggressive conservative therapy for at least 4-6 weeks. Provider has failed to document aggressive conservative treatment. Patient is on no noted pain medications. Does not meet criteria.4) Reported >70%improvement in pain lasting at least 6weeks with prior injections. Fails criteria.Patient has yet to any criteria needed to recommend SI joint block. SI joint block is not medically necessary.

Right prirformis injection under ultrasound guidance: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines: Hip and Pelvic Chapter, Piriformis injections

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, Piriformis Injections

Decision rationale: MTUS Chronic pain and ACOEM guidelines do not have any sections that deal with this topic. Official Disability Guidelines (ODG) recommend after 1month trial of physical therapy and diagnosis of Piriformis Syndrome. Provider has failed to provide an objective exam that is consistent with Piriformis Syndrome. Conservative therapy is successful in most cases and recommendation is aggressive physical therapy (PT) with home exercise treatment. Injection is only recommended when pain is refractory. Patient does not meet criteria to recommend injection. Piriformis Injection is not medically necessary.

Prednisone 10mg #37: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment in Workers' Compensation: Pain, Oral corticosteroids

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-Thoracic and Lumbar, Corticosteroids(Oral/parenteral/IM for low back pain)

Decision rationale: MTUS Chronic pain and ACOEM guidelines do not have any sections that deal with this topic. Official Disability Guidelines (ODG) recommend limited use of steroids only under specific criteria. 1) Clear signs of radiculopathy: Fails criteria2) Risk of steroids should be discussed: Fails criteria. There is a note concerning discussion about "side effects" of the medications which is not enough documentation to support a proper decision concerning actual risk of the medication.3) Patient should be aware of limited evidence. Fails criteria4) Most utility is during acute phase. Limited utility in chronic phase. Fails criteria.Patient does not meet any criteria for steroid therapy. Prednisone is not medically necessary.

Tizanidine 4mg #60 times 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain); Antispasticity/Antispasmodic drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity/antispasmodics Page(s): 60.

Decision rationale: Zanaflex (Tizanidine) is an antispasmodic muscle relaxant. It is FDA approved for muscle spasms. As per MTUS guidelines, muscle relaxants should be used for short term use and for flare ups only. There is documentation of muscle spasms on exam. Medication may be beneficial but the number of tablets does not support a plan for short term use. Tizanidine is not medically necessary.