

Case Number:	CM14-0094747		
Date Assigned:	07/25/2014	Date of Injury:	05/01/2013
Decision Date:	09/22/2014	UR Denial Date:	06/11/2014
Priority:	Standard	Application Received:	06/23/2014

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, has a subspecialty in Pain Medicine and is licensed to practice in Oklahoma and 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 43-year-old female who reported an injury on 05/01/2013. She was reportedly slammed on the floor. On 05/08/2014, the injured worker presented with low back pain. Upon examination, the injured worker was in visible discomfort and shifting weight and position from standing to sitting to lying to relieve pain. There was an antalgic gait and decreased range of motion of the lumbar spine in all planes limited to pain. There was decreased sensation in the L4-S1 dermatomes on the left. There was 4+/5 left TA, EHL, inversion, eversion, and plantar flexion. There was a positive straight leg raise test to the left and positive pain on facet loading bilaterally. There was a positive Faber and a positive left SI tenderness. An MRI performed on 12/16/2013 revealed postoperative changes L5-S1 with enhancing perineural scar tissue with L5-S1 mild to moderate left neural foraminal narrowing, left sided lumbar radiculopathy, status post microlumbar decompression surgery in 2010, and left sacroiliitis. Prior therapy included medications. The provider recommended Flexeril, bilateral SI joint injections, and a consultation. 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:

Flexeril 7.5 mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment for Workers Compensation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 41.

Decision rationale: The request for Flexeril 7.5 mg #30 is not medically necessary. The California MTUS Guidelines recommend Flexeril as an option for a short course of therapy. The greatest effect of the medication is in the first 4 days of treatment, suggesting that shorter courses may be better. Treatment should be brief. The provided medical records lacked documentation of significant objective functional improvement with the medication. The provider's rationale for the request was not provided. As such, the request is not medically necessary.

Bilateral SI joint injections: 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 for Workers Compensation.

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, Intra-articular steroid hip injection (IASHI).

Decision rationale: The request for Bilateral SI joint injections is not medically necessary. The Official Disability Guidelines do not recommend intra-articular steroid hip injections in early hip osteoarthritis. It is under study for moderately advanced or severe hip osteoarthritis, but if used, should be in conjunction with fluoroscopic guidance. It is recommended as an option for short term pain relief in hip trochanteric bursitis. Intra-articular glucocorticoid injection with or without elimination of weight bearing does not reduce the need for a total hip arthroplasty in injured workers with rapidly destructive hip osteoarthritis. As the guidelines do not recommend intra-articular steroid hip injections, a bilateral SI joint injection would not be warranted. There is lack of exceptional factors provided in the documentation submitted to support approving outside the guideline recommendations. As such, the request is not medically necessary.

Consultation with a general practitioner for weight loss: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 6, page 163.

Decision rationale: The request for Consultation with a general practitioner for weight loss is not medically necessary. The California MTUS/ACOEM Guidelines state that a consultation is intended to aid in assessing the diagnosis, prognosis, therapeutic management, determination of

medical disability, and permanent residual loss and/or the examinee's fitness for return to work. There is lack of documentation of the injured worker's height and weight, and there is no indication of any lifestyle modifications to include diet and exercise. As such, the request is not medically necessary.