

Case Number:	CM14-0141465		
Date Assigned:	09/10/2014	Date of Injury:	05/06/2010
Decision Date:	10/22/2014	UR Denial Date:	08/08/2014
Priority:	Standard	Application Received:	09/01/2014

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 Orthopedic Spine Surgeon 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 49-year-old female who reported an injury on 05/06/2010. The mechanism of injury involved a fall. The current diagnosis is herniated disc. The injured worker was evaluated on 06/30/2014 with complaints of left shoulder pain and bilateral SI joint pain. Previous conservative treatment is noted to include medication management, physical therapy, chiropractic treatment, and injection therapy. Physical examination on that date revealed tenderness to palpation of the thoracic and lumbar spine, decreased range of motion secondary to pain, positive Spurling's maneuver, left shoulder AC joint tenderness, positive Neer and Hawkins testing, positive SI joint tenderness bilaterally, and positive Faber testing. Treatment recommendations at that time included continuation of the current medication regimen, a repeat MRI of the thoracic spine, and a bilateral SI joint fixation and fusion. A Request for Authorization Form was then submitted on 07/23/2014 for an MRI of the thoracic spine, an SI joint fixation and fusion, Anaprox 550 mg, Doral 15 mg, Norco 10/325 mg, Prilosec 20 mg, Ultram 150 mg, and flurbiprofen.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the Thoracic Spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: California MTUS/ACOEM Practice Guidelines state if physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause. There is no documentation of a significant change or worsening of symptoms or physical examination findings that would warrant the need for a repeat thoracic spine MRI. As the medical necessity has not been established, the current request is not medically appropriate.

Both SI joint Fixation and Fusion: 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), Low Back, Criteria for Lumbar Spinal Fusion

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 fusion.

Decision rationale: The Official Disability Guidelines state indications for an SI joint effusion include post-traumatic injury of the SI joint, failure of nonoperative treatment, chronic pain, a diagnosis confirmed by pain relief with an intra-articular sacroiliac joint injection, and after an assessment of preoperative and postoperative general health and function. As per the documentation submitted, the injured worker has exhausted conservative treatment. However, there is no evidence of pain relief with an intra-articular sacroiliac joint injection under fluoroscopic guidance. Therefore, the current request is not medically appropriate.

Flurbiprofen: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-72.

Decision rationale: California MTUS Guidelines state NSAIDS are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. For acute exacerbations of chronic pain, NSAIDS are recommended as a second line option after acetaminophen. There is no strength, frequency or quantity listed in the current request. Therefore, the request is not medically appropriate.