

Case Number:	CM13-0058832		
Date Assigned:	12/30/2013	Date of Injury:	11/20/1997
Decision Date:	06/10/2014	UR Denial Date:	11/21/2013
Priority:	Standard	Application Received:	11/27/2013

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 & Rehabilitation and is licensed to practice in Maryland. 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 patient is a 50 year old male who had a work injury dated 11/20/11. The diagnoses include failed low back surgery syndrome, spinal fusion, status post fusion at L4-S1 in October of 2010, external sphincter bladder dyssynergia, cervical sprain/strain, and chronic high dose opiate use. There is a request for bilateral sacroiliac injections. There is an 8/7/13 PR-2 report that states that the patient presents for follow up regarding his cervical and lumbar spine complaints. He currently rates his symptoms as 8/10 on the pain scale. He continues to have bilateral lower extremity numbness and tingling. The patient was diagnosed with bladder injury in the past and he continues to have difficulty emptying his bladder. The physical exam revealed Gait is antalgic with abnormal heel/toe walk. The patient is ambulating with the use of a single point cane. He has tenderness to palpation of the cervical spine as well as the lumbar spine. Cervical and lumbar spine range of motion is decreased in all planes. The patient displays 4+/5 strength to the bilateral upper and lower extremities on motor exam. There are decreased left C5, C6, and C7 dermatomes on sensory exam. Reflexes of the bilateral upper and lower extremities are intact throughout. Examination results indicate negative bilateral straight leg raise, negative bilateral Lasegue's test, negative bilateral clonus, negative bilateral Tinel's test, negative bilateral Hoffman's test, negative bilateral Spurling's, and positive facet loading challenge in the lumbar spine. The patient experiences pain with extension of the lumbar spine. There is a QME dated 4/12/13 which states that on medical record review it was noted that the patient worked through 11/11 when he had excruciating back pain. He was permanently disabled with failed back surgery syndrome and referred to pain management doctors. He was given doses of Oxycontin, gradually increased. He had sacroiliac joint injections with minimal help. The CT myelogram of the lumbar spine dated April 19, 2012 revealed the following findings: Postoperative changes with bilateral pedicle screws and rods, as well as intervertebral disc graft seen at the L4-5 and

L5-S1 levels. (2) Once again noted is graft material about the posterior spinous process at L3-L4 levels, which are still fragmented, suggesting only partial fusion. (3) Mild to moderate degenerative changes are seen from the L3 -4 and L5-S1 level, as well as at the L1-2 level, as discussed. A 3/11/13 electrodiagnostic study revealed evidence of chronic bilateral L5 radiculopathy. 3. There is no electrodiagnostic evidence of focal nerve entrapment, cervical radiculopathy or generalized peripheral neuropathy affecting the upper or lower limbs.

IMR ISSUES, DECISIONS AND RATIONALES

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

BILATERAL SACROILIAC 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 (ODG) Pelvis/Hip Chapter.

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

Decision rationale: The ODG states that a patient's history and physical findings should suggest sacroiliac joint pathology with at least 3 positive exam findings in order for a sacroiliac joint block recommendation. Furthermore, the ODG indicates whether a sacroiliac joint injection is appropriate should be based on if the patient has not had a positive block and a second block is not performed. The documentation does not indicate physical exam findings of sacroiliac pathology. Furthermore, it is not clear if patient has had prior sacroiliac injections as a QME document dated 4/12/13 states that patient has not had a positive response to prior sacroiliac injections. Without criteria of sacroiliac pathology on physical exam and prior unsuccessful sacroiliac injections the request for bilateral sacroiliac injections is not medically necessary and appropriate.