

<b>Case Number:</b>	CM13-0063111		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	01/15/2011
<b>Decision Date:</b>	04/18/2014	<b>UR Denial Date:</b>	11/14/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/09/2013

### 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 and Rehabilitation and is licensed to practice in Illinois. 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 56-year-old female who reported an injury on 01/15/2011 due to a slip and fall that caused her to land on the right side of her body. The patient reportedly sustained injury to her right leg, abdomen, rib cage, wrist, shoulder, neck, and low back. The patient's treatment history included transforaminal epidural steroid injections that provided 50% improvement for approximately 8 weeks. The patient also underwent a right sacroiliac joint injection in 04/2013 that provided 50% pain relief and improvement in function for approximately 8 weeks. The patient's most recent clinical documentation noted that the patient had low back pain radiating into the bilateral lower extremities rated at 9/10. It was also noted that the patient had developed bilateral sacroiliac joint pain radiating into the buttocks. Physical findings included positive sacroiliac joint thrust test, a positive Gaenslen's sign, a positive Patrick's/Fabre's sign, and a positive Adson's sign. The patient had significantly reduced lumbar range of motion and decreased motor strength of the bilateral lower extremities rated at 4/5. The patient's diagnoses included lumbar sprain/strain, multiple disc herniations, lumbar radiculitis, lumbar paraspinal spasming, and sacroiliitis of the bilateral sacroiliac joints. The patient's treatment plan included bilateral sacroiliac joint injections under fluoroscopic guidance.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**BILATERAL SCROILIAC JOINT INJECTION UNDER FLUOROSCOPIC GUIDANCE TO BE PERFORMED AT [REDACTED] :**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Alternate Guideline was consulted.

**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 Chapter, Sacroiliac joint blocks.

**Decision rationale:** The requested bilateral sacroiliac joint under fluoroscopic guidance is not medically necessary or appropriate. Official Disability Guidelines recommend repeat sacroiliac joint injections be based on at least 70% pain relief for approximately 6 weeks. As the patient only had 50% pain relief on the right side from a previous injection, an additional injection on the right side would not be supported. Also, there is no documentation that the patient has ever received a sacroiliac block on the left side and there is no documentation that the patient has received any conservative treatment for the newly developed left sided sacroiliac joint pain. Therefore, the requested bilateral sacroiliac joint injection under fluoroscopic guidance to be performed at [REDACTED] is not medically necessary or appropriate.

**BILATERAL TRANSFORMINAL LUMBAR EPIDURAL STEROID INJECTION AT L4-5 AND L5-S1 LEVELS TO BE PERFORMED AT [REDACTED]**

[REDACTED] Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46.

**Decision rationale:** The requested bilateral transforaminal lumbar epidural steroid injections at the L4-5 and L5-S1 levels are not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends repeat injections be based on documented objective functional improvement and pain relief of at least 50% for 6 to 8 weeks following the initial injection. The clinical documentation submitted for review does indicate that the patient had 50% pain relief for approximately 8 weeks following the initial injections. However, the clinical documentation fails to provide any evidence of objective functional improvement or associated medication reduction as a result of the previous injection. As such, the requested bilateral transforaminal lumbar epidural steroid injection at the L4-5 and L5-S1 levels to be performed at [REDACTED] is not medically necessary or appropriate.