MAXIMUS Federal Services

Case Number:	CM13-0063643		
Date Assigned:	05/14/2014	Date of Injury:	08/04/2008
Decision Date:	07/31/2014	UR Denial Date:	11/26/2013
Priority:	Standard	Application Received:	12/10/2013

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 Occupational 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:

The patient is a 52-year-old male who has submitted a claim for sacroilitis, left lumbar radiculopathy, lumbar disc protrusion, and mood disorder associated with an industrial injury date of 8/4/08. Medical records from 2009 to 2013 were reviewed. The patient complained of left-sided low back pain, buttock pain, and posterior thigh pain. The patient had a sitting tolerance of 40 minutes, standing tolerance of one hour, and walking tolerance for 1-2 hours. Muscle strength of left ankle dorsiflexors, evertors, and knee flexors were graded 4+/5. Left knee extensor muscle strength was 5-/5. Straight leg raise at the left resulted to back pain. Tenderness was noted at left sacroiliac joint. Fortin finger sign was positive. Sacroiliac maneuvers were markedly positive, including distraction test, thigh-thrust test, and FABER test. Reflexes were normal. EMG/NCV from 6/18/09 showed electrodiagnostic evidence for left lumbar posterior rami denervation, without evidence for an active lumbosacral radiculopathy on both sides. MRI of the lumbar spine, dated 4/16/13, showed multilevel degenerative disc disease without significant canal stenosis. Treatment to date has included lumbar transforaminal epidural injection, physical therapy, chiropractic care, use of a TENS unit, and medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

CT WITHOUT CONTRAST PELVIS: 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 American College of Radiology, Practice Guideline for the Performance of Computed Tomography (CT) of the Pelvis.

Decision rationale: The California MTUS does not specifically address this topic, so the American College of Radiology, Practice Guideline for the Performance of Computed Tomography (CT) of the Pelvis was used instead. The guidelines state that the indications for pelvis CT examination includes but are not limited to evaluation of pelvic pain, evaluation of pelvic inflammatory processes, evaluation of abdominal or pelvic trauma, clarification of findings from other imaging studies or laboratory abnormalities, and guidance for interventional or therapeutic procedures within the abdomen or pelvis. In this case, the progress report from 11/5/13 cited that the patient had multilevel degenerative lumbar disc disease, and clinically presented with severe left sacroiliac joint pain. The rationale for requesting a CT of the pelvis was to characterize the pathology around the sacroiliac joint. The was no indication as to why x-rays, a CT scan, or an MRI of the left sacroiliac joint were not requested instead. Guideline criteria of a CT scan of the pelvis were not met. As such, the request is not medically necessary.

FLUOROSCOPICALLY GUIDED ANESTHETIC INJECTION-LEFT SACROILIAC JOINT: 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): 309. Decision based on Non-MTUS Citation Official Disability Guidelines.

Decision rationale: As stated on page 309 of the ACOEM, sacroiliac joint injections are of questionable merit. In addition, the Official Disability Guidelines state that criteria for SI joint injections include clinical sacroiliac joint dysfunction, failure of at least 4-6 weeks of aggressive conservative therapy, and the history and physical should suggest the diagnosis (with documentation of at least 3 positive exam findings). In this case, fluoroscopically guided anesthetic injection into the left sacroiliac joint was requested for diagnostic purposes. No steroid will be utilized. Treatment plan included a sacroiliac fusion if with positive result, or a spinal cord stimulator if with negative findings. A progress report from 11/5/13 cited that the patient had multilevel degenerative lumbar disc disease, and clinically presented with severe sacroiliac pain. On physical examination, tenderness was noted at left sacroiliac joint. Fortin finger sign was positive. Sacroiliac maneuvers were markedly positive, including distraction test, thigh-thrust test, and FABER test. However, this review involves a simultaneous request for CT scan of the pelvis, which has been deemed not medically necessary. It is reasonable to request appropriate radiological assessment of the affected SI joint prior to recommending a SI joint injection; further management is dependent on imaging outcomes. Hence, the medical necessity for SI joint injection was not established. As such, the request is not medically necessary.