

<b>Case Number:</b>	CM14-0004291		
<b>Date Assigned:</b>	02/05/2014	<b>Date of Injury:</b>	03/21/2012
<b>Decision Date:</b>	07/14/2014	<b>UR Denial Date:</b>	01/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/10/2014

### 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 & Rehabilitation, has a subspecialty in Pain Medicine, and is licensed to practice in Texas and Oklahoma. 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 41-year-old female who reported an injury on 03/21/2012. The mechanism of injury was not specifically stated. Current diagnoses include status post positive fluoroscopically guided diagnostic left sacroiliac joint injection, left sacroiliac joint pain, left cervical facet joint pain, left lumbar facet joint pain, lumbar disc bulge, left lumbar sprain, left knee internal derangement, and status post left knee surgery. The injured worker was evaluated on 01/21/2014 with complaints of left sided lower back pain and left buttock pain. The injured worker was status post sacroiliac joint injection. Current medications include ibuprofen 600 mg and Vicodin 5 mg. Physical examination revealed tenderness to palpation of the left sacroiliac joint, restricted lumbar range of motion, positive lumbar discogenic provocative maneuvers, positive Gaenslen's testing, positive Patrick's and Yeoman's testing, and restricted lower extremity range of motion. Treatment recommendations included an appeal request for ibuprofen 600 mg and a sacroiliac joint radiofrequency ablation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **LEFT SACROILIAC JOINT RADIOFREQUENCY NERVE ABLATION (NEUROTOMY/RHIZOTOMY) FLURORSCOPICALLY GUIDED: Upheld**

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

**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 radiofrequency neurotomy.

**Decision rationale:** Official Disability Guidelines state sacroiliac joint radiofrequency neurotomy is not recommended. Larger studies are needed to confirm results and determine optimal candidates and treatment parameters for this disorder. Therefore, the current request is not medically appropriate. As such, the request is non-certified.

**IBUPROFEN 600MG TID #60:** Upheld

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

**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 after acetaminophen. The injured worker has utilized ibuprofen since 05/2013. Despite the ongoing use of this medication, the injured worker continues to report persistent pain. Guidelines do not recommend long term use of this medication. As such, the request is non-certified.

**HYDROCODONE 5/325MG 1 TAB PO BID PRN PAIN #60 WITH 1 REFILL:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 82-88.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

**Decision rationale:** California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The injured worker has continuously utilized this medication since 05/2013 without any evidence of objective functional improvement. Therefore, the ongoing use cannot be determined as medically appropriate. As such, the request is non-certified.