

<b>Case Number:</b>	CM14-0100973		
<b>Date Assigned:</b>	07/30/2014	<b>Date of Injury:</b>	03/12/2010
<b>Decision Date:</b>	09/03/2014	<b>UR Denial Date:</b>	06/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/30/2014

### 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 Surgery, and is licensed to practice in New York. 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 has chronic low back pain. Physical exam shows increased pain with sacroiliac joint palpation and hip flexion. There is decreased lumbar range of motion and a normal gait. Neurologic examination is normal in the bilateral lower extremities. There is tenderness palpation of the lumbar spine. Lumbar MRI from October 2013 shows L3-4 retrolisthesis with Ace bandages at L4-5 and L5-S1. Patient had right L5-S1 hemilaminotomy surgery. Patient had previous anterior L5 and L4 fusion. Patient has been diagnosed with failed back syndrome and sacroiliitis. Treatment has included medications and physical therapy and Corticosteroid injections. At issue is whether SI joint injections medically necessary.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Bilateral Sacroiliac joint injection under fluoroscopy with anesthesia:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American Pain Society (APS) and Official Disability Guidelines (ODG), Hip and Pelvis (Acute and Chronic).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: ODG low back chapter, MTUS low back chapter.

**Decision rationale:** MTUS guidelines do not recommend SI joint injections. ODG guidelines indicate there is insufficient evidence to evaluate the validity of diagnostic sacroiliac injections. In addition, the patient does not have radiographic evidence of SI joint pathology. There is no reason documentation of SI joint physical therapy. Since the patient has not had a recent trial and failure conservative measures, SI joint injection is not medically necessary at this time. Criteria for SI joint injection not met.

**Norco 10/325 mg, QTY: 60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Hydrocodone/Acetaminophen.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: MTUS chronic pain treatment guidelines.

**Decision rationale:** The patient has had narcotic therapy for chronic back pain. Guidelines do not recommend long-term narcotic therapy for chronic back pain. The patient has had previous medical treatment. The medical records do not indicate that the patient has a functional capacity evaluation demonstrating improve functional outcomes with Norco. There is no documentation of this medication and had a significant impact on the patient's quality-of-life. Criteria for additional narcotic use not met.

**Physical therapy for the lumbar spine, QTY: 12 sessions:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**Decision rationale:** Criteria for lumbar spine physical therapy is not met in this case. The medical records indicate that the patient has been doing her back physical therapy for years. Additional physical therapy for chronic pain is only wanted a functional proven is documented. The patient has chronic pain and functional improvement with physical therapy is not documented medical records. As per guidelines there is no reason to continue physical therapy without evidence of functional improvement. The request for more physical therapy is not medically necessary. Guidelines for additional physical therapy not met.

**Deuxis (ibuprofen and famotidine) 800/26.3 mg, QTY: 90:** 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), Pain (Chronic).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: MTUS chronic pain treatment guidelines.

**Decision rationale:** This medicine is not medically necessary in this case. Guidelines indicate that this is not a first-line drug treatment medicine. Medical records indicate that the patient has had benefited her previous NSAID usage. The patient's nor is it can easily be controlled with an acid medication to protect GI symptoms. Second line NSAID medication is not medically necessary.