

Case Number:	CM14-0118526		
Date Assigned:	08/06/2014	Date of Injury:	10/04/2010
Decision Date:	09/23/2014	UR Denial Date:	07/03/2014
Priority:	Standard	Application Received:	07/28/2014

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 and Rehabilitation has a subspecialty in Pain 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 injured worker is a 57-year-old male, who reported an injury on 10/04/2010; while driving his patrol vehicle, he came to an intersection and suddenly lost control of his vehicle, and crashed into a tree. Diagnoses were L4-5, 2 mm disc bulge with left neural foraminal stenosis with compression of exiting left L4 nerve root with bilateral recess stenosis with right sided postsurgical changes per CT scan, 04/20/2014; spondylolisthesis of L4 on L5; L5-S1, 2 to 3 mm disc bulge with central stenosis and bilateral recess stenosis; status post L4-5 right hemilaminotomy and medial right facetectomy. Past treatments were medications and physical therapy. Diagnostic studies were MRI of the lumbar spine, EMG/NCV, CT of the lumbar spine on 04/20/2014. The CT scan of the lumbar spine revealed at L2-3, there was minimal disc bulge without significant stenosis; at L3-4, there was mild disc bulge and mild left lateral/interforaminal disc protrusion; at L4-5, there was left neural foraminal stenosis with compression of exiting left L4 nerve root with mild bilateral lateral recess stenosis with right sided postsurgical changes and slight ventral spondylolisthesis at the L4 and L5 with a 2 mm disc bulge; at L5-S1, there was mild central stenosis with mild bilateral recess stenosis with a 2 mm to 3 mm disc bulge. Surgical history was an L4-5 decompression. Physical examination on 05/27/2014 revealed complaints of ongoing low back pain rated at an 8/10 to 9/10 on the pain scale. The injured worker continued to report pain along the right anterior thigh. There were complaints of ongoing weakness sensation of the back and lower extremities. Examination of the lumbar spine revealed palpation elicited tenderness over the right flank, over the abdominal oblique muscles and rectus abdominal muscle. Lower extremity deep tendon reflexes: For the patella, on the right it was a 2+, left a 2+; hamstring for the right was a 2+, left a 0; Achilles was a 2+ on the right, a 2+ on the left. Sensory examination revealed diminished sensation along the L5 dermatome distribution on the right. Medications were metoprolol, omeprazole, aspirin,

benazepril, Theramine, Hypertensa, hydrochlorothiazide, cyclobenzaprine, tramadol, and amlodipine. Treatment plan was for anterior lumbar interbody fusion at the L4-5 and L5-S1 levels, pre-op medical clearance, and home health care prior to discharge. The rationale was not submitted. The Request for Authorization was submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Transfacet ESI Right Sacroiliac Joint Injection: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip & Pelvis Chapter.

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, Sacroiliac Joint Blocks.

Decision rationale: The Official Disability Guidelines state sacroiliac joint block is an option if failed at least 4 to 6 weeks of aggressive conservative therapy as indicated. Sacroiliac dysfunction is poorly defined, and the diagnosis is often difficult to make due to the presence of other low back pathology (including spinal stenosis and facet arthropathy). The diagnosis is also difficult to make, as pain symptoms may depend on the region of the SI joint that is involved (anterior, posterior, and/or extra-articular). Pain may radiate into the buttock, groin, and entire ipsilateral lower limb, although if pain is present above L5, it is not felt to be from the SI joint. There is limited research suggesting therapeutic blocks offer long term effect. There should be evidence of a trial of aggressive conservative treatment (at least 6 weeks of a comprehensive exercise program, local icing, mobilization/manipulation, and anti-inflammatories) as well as evidence of a clinical picture that is suggestive of sacroiliac injury and/or disease prior to a first SI joint block. If helpful, the blocks may be repeated. However, the frequency in this injections should be limited, with attention placed on the comprehensive exercise program. The injured worker did not have 3 positive exam findings submitted. There were no diagnostic studies submitted for the sacroiliac joint. It was not reported that the injured worker had failed 4 to 6 weeks of aggressive conservative therapy. Therefore, the request is not medically necessary.