

<b>Case Number:</b>	CM14-0120718		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	06/03/1992
<b>Decision Date:</b>	09/11/2014	<b>UR Denial Date:</b>	07/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/31/2014

### 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, and is licensed to practice in Texas & 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 71-year-old male who reported an injury on 06/03/1992. The mechanism of injury was due to a slip and fall. The diagnoses included Lumbar Disc Disease, Lumbar Radiculitis, Post Laminectomy Syndrome, Chronic Pain, and Sacroiliac Joint Disease. The previous treatments included medication. The diagnostic testing included a lumbar CT. Within the clinical note dated 07/03/2014, it was reported the injured worker complained of moderate to severe constant low back pain which increased with activity. The injured worker complained of bilateral tenderness to palpation over the sacroiliac joint. Upon the physical examination the provider noted the injured worker's lumbar range of motion was flexion at 20 degrees, and extension at 5 degrees. The provider indicated the injured worker had deep tendon reflexes of 0 to 1+ bilateral. Motor strength was 5 out of 5 on the left side and 4 out of 5 on the right side. The injured worker had diminished sensation over the left anterolateral thigh and calf. The provider requested a Bilateral Sacroiliac Joint Injection, and Xanax. However, a rationale was not provided for clinical review. The Request for Authorization form was submitted and dated on 07/17/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Bilateral Sacroiliac (SI) Joint Injection:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Hip/Pelvis, Sacroiliac joint blocks.

**Decision rationale:** The request for Bilateral Sacroiliac Joint Injection is not medically necessary. The Official Disability Guidelines recommend a sacroiliac joint injection as an option if the injured worker has failed at least 4 to 6 weeks of aggressive conservative therapy as indicated below. The history and physical should suggest the diagnosis with documentation of at least 3 positive exam findings of specific test for motion palpation and pain provocation have been prescribed for sacroiliac joint dysfunction including cranial shear test, extension test, Flamingo test, Fortin finger test, Gaenslen's test, Patrick's test. The guidelines note diagnostic evaluation must first address any possible pain generators. There is lack of objective findings indicating the injured worker had sacroiliac joint dysfunction. Additionally, there is lack of clinical documentation of failure of 4 to 6 weeks of aggressive conservative care. There is lack of documentation indicating the physical exam provided 3 positive exam findings. There is lack of significant neurological deficits such as decreased sensation or motor strength in a specific dermatomal distribution. Therefore, the request is not medically necessary.

**Xanax # 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.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

**Decision rationale:** The request for Xanax #90 is not medically necessary. The California MTUS Guidelines do not recommend Xanax for long term use because long term efficacy is not proven and there is risk of dependence. The guidelines recommend the limited use of Xanax to 4 weeks. The injured worker had been utilizing the medication since at least 01/2014 which exceeds the guidelines recommendation of short term use of 4 weeks. There is lack of documentation indicating the efficacy of the medication as evidence by significant functional improvement. The request submitted failed to provide the frequency of the medication. Therefore, the request is not medically necessary.