

Case Number:	CM14-0159164		
Date Assigned:	10/02/2014	Date of Injury:	11/04/1997
Decision Date:	10/30/2014	UR Denial Date:	09/09/2014
Priority:	Standard	Application Received:	09/29/2014

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 Pain Management, has a subspecialty in Interventional Spine 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 69-year-old female with date of injury of 11/04/1997. The listed diagnoses per [REDACTED] from 08/15/2014 are: 1. Status post bilateral total hip replacement. 2. Status post L4-L5, L5-S1 fusion. 3. Pubic symphysis arthralgia. 4. Bilateral sacroiliac arthralgia. 5. Left more than right Dupuytren's contracture. 6. Bilateral sciatica. According to this report, the patient complains of low back pain referring to the left more than the right lower extremity. The patient rates her pain without medication 4/10 to 5/10, and with medication, 2/10 to 3/10 in severity. Trigger point injections were provided on 07/03/2014 which provided relief for 2 to 3 days. The examination shows sensibility is intact in the lumbar spine with hyperesthesias of the left lateral foot. Motor strength is 5/5 throughout both lower extremities except for the hips bilaterally at 4/5 secondary to pain. Straight leg raise is 40 degrees with pain referral into the left lower extremity. Palpation reveals hyperalgesia at the right L4-L5 level, more on the left than the right sacroiliac joint regions. Patient demonstrates an antalgic gait and ambulates with a walker. The utilization review denied the request on 09/09/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left sacroiliac lateral branch block at S1, S2 and S3: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Hip & Pelvis; Sacroiliac joint blocks

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG Low Back Chapter Facet joint diagnostic blocks (injections).

Decision rationale: This patient presents with low back pain with radiating symptoms to the bilateral lower extremities. The treater is requesting a left sacroiliac lateral branch block at S1, S2, and S3. The MTUS and ACOEM Guidelines do not address sacroiliac joint injections; however, ODG Guidelines recommends SI joint injections as an option if the patient has 3 positive exam findings for SI joint syndrome; diagnostic evaluation have addressed other possible pain generators; at least 4 to 6 weeks of aggressive conservative therapy including physical therapy, home exercises, and medication management. Also, a positive diagnostic response is recorded as 80% for the duration of the local anesthetic. If the first block is not positive, a second diagnostic block is not performed. The x-ray of the lumbar spine from 07/01/2014 showed extensive spinal fusion. No complicating process is detected and no pathologic motion is seen on flexion and extension views. The lumbar myelogram from 11/02/2010 showed prior spinal fusion from T12 to L5 with posterior fusion rods and pedicle screws, interbody spacers, left lateral fixation plate, and vertebral body screws at L3-L4. The 08/15/2014 report notes hyperesthesias of the left lateral foot with motor strength of 5/5 throughout both lower extremities except for the hips bilaterally at 4/5 secondary to pain. Straight leg raise is 40 degrees with pain referral into the left lower extremity. In the same report, the patient reports "low back pain referring to the left more than the right lower extremity." The records do not show any previous sacroiliac lateral branch blocks at S1, S2, and S3. None of the reports document 3 positive SI joint examination and evaluation for other pain generators. In this case, the patient has failed to meet the criteria required by MTUS for an SI joint injection. ODG guidelines also discuss SI joint injections but the dorsal median branch blocks for SI joint. RF (Radio Frequency) ablation of SI joints is not recommended per ODG and therefore, there would be no need for DMB's for SI joints. As such, the request of Left sacroiliac lateral branch block at S1, S2 and S3 is not medically necessary and appropriate.

Right SI (Sacroiliac) lateral branch block at S1, S2 and S3: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Hip & Pelvis; Sacroiliac joint blocks

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG Low Back Chapter Facet joint diagnostic blocks (injections).

Decision rationale: This patient presents with low back pain with radiating symptoms to the bilateral lower extremities. The treater is requesting a left sacroiliac lateral branch block at S1, S2, and S3. The MTUS and ACOEM Guidelines do not address sacroiliac joint injections; however, ODG Guidelines recommends SI joint injections as an option if the patient has 3 positive exam findings for SI joint syndrome; diagnostic evaluation have addressed other possible pain generators; at least 4 to 6 weeks of aggressive conservative therapy including physical therapy, home exercises, and medication management. Also, a positive diagnostic

response is recorded as 80% for the duration of the local anesthetic. If the first block is not positive, a second diagnostic block is not performed. The x-ray of the lumbar spine from 07/01/2014 showed extensive spinal fusion. No complicating process is detected and no pathologic motion is seen on flexion and extension views. The lumbar myelogram from 11/02/2010 showed prior spinal fusion from T12 to L5 with posterior fusion rods and pedicle screws, interbody spacers, left lateral fixation plate, and vertebral body screws at L3-L4. The 08/15/2014 report notes hyperesthesias of the left lateral foot with motor strength of 5/5 throughout both lower extremities except for the hips bilaterally at 4/5 secondary to pain. Straight leg raise is 40 degrees with pain referral into the left lower extremity. In the same report, the patient reports "low back pain referring to the left more than the right lower extremity." The records do not show any previous sacroiliac lateral branch blocks at S1, S2, and S3. None of the reports document 3 positive SI joint examination and evaluation for other pain generators. In this case, the patient has failed to meet the criteria required by MTUS for an SI joint injection. ODG guidelines also discuss SI joint injections but the dorsal median branch blocks for SI joint. RF ablation of SI joints is not recommended per ODG and therefore, there would be no need for DMB's for SI joints. As such, Right SI (Sacroiliac) lateral branch block at S1, S2 and S3 is not medically necessary and appropriate.