

<b>Case Number:</b>	CM14-0168389		
<b>Date Assigned:</b>	10/16/2014	<b>Date of Injury:</b>	12/23/1997
<b>Decision Date:</b>	12/10/2014	<b>UR Denial Date:</b>	09/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/13/2014

### 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 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 57-year-old male with a date of injury of 12/23/1997. The listed diagnoses per [REDACTED] are: 1. Bilateral SI radiculopathy. 2. Status post L5-S1 fusion. 3. L4-L5 spinal stenosis on the right. 4. Bilateral SI dysfunction. According to progress report 09/08/2014, the patient presents with continued bilateral SI joint pain rated as 7 on VAS with and without the use of medications. The patient has increasing complaints of pain in the bilateral lower extremities from the shins/calves to the bottom and top of feet rated as 10 on a VAS with and without medications. The patient is currently utilizing Norco 10/325 mg and Tramadol 50 mg. Examination of the lumbar spine revealed palpable tenderness of the paravertebral muscles bilaterally. There is evidence of tenderness over the sacroiliac joints bilaterally. The patient has a positive Fortin's sign, positive pelvic compression, and positive Gaenslen's sign bilaterally. There is decreased range of motion right more than left at the L4 and L5 dermatomes. Straight leg raise is positive on the right. MRI of the lumbar spine from 10/17/2013 revealed post-surgical changes identified at L5-S1 with disk space level fusion and laminectomy defect with scar-type changes. There is moderate right-sided and mild to moderate left-sided foraminal narrowing in the L4-L5 due to degenerative changes. Treater states that the patient was sent for an updated x-ray of the lumbar spine which showed "mild degenerative disk disease at L4-L5 with facet arthropathy." Treater is requesting authorization for an updated MRI of the lumbar spine with contrast and bilateral SI radiofrequency ablation. Utilization review denied the request on 09/18/2014. Treatment reports from 12/16/2013 through 09/08/2014 were reviewed.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI of the lumbar spine with contrast:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back chapter, MRIs (magnetic resonance imaging)

**Decision rationale:** This patient presents with bilateral SI joint pain and increasing complaints of pain in the bilateral lower extremities from the shins/calves to the bottom of the feet. The treater is requesting an MRI of the lumbar spine with contrast. The medical file provided for review indicates the patient underwent an MRI of the lumbar spine on 12/07/2011, repeat MRI of the L-spine on 10/17/2013, and an x-ray on 09/08/2014 which revealed mild degenerative disk disease at L4-L5 with facet arthropathy. For special diagnostics, ACOEM Guidelines page 303 states "unequivocal objective findings that identify specific nerve compromise on the neurological examination is sufficient evidence to warrant imaging in patients who do not respond well to treatment and who would consider surgery as an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study." In this case, there are no new injuries, no significant changes in examination, no bowel/bladder symptoms, or new location of symptoms that would require additional investigation. The requested repeat MRI of the lumbar spine is not medically necessary.

**Radiofrequency ablation of left SI joints:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation ODG Hip and 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 (Acute and Chronic) chapter, Sacroiliac joint radiofrequency neurotomy

**Decision rationale:** This patient presents with bilateral SI joint pain with increasing complaints of pain in the bilateral lower extremities from the shins/calves to the bottom of the feet. The treater is requesting a radiofrequency ablation of the left SI joint. The ACOEM and MTUS guidelines do not discuss Radiofrequency ablation of the sacroiliac joints. ODG Guidelines, Hip and Pelvis (Acute and Chronic) chapter, has the following regarding Sacroiliac joint radiofrequency neurotomy, "Not recommended. Multiple techniques are currently described: (1) a bipolar system using radiofrequency probes (Ferrante, 2001); (2) sensory stimulation-guided sacral lateral branch radiofrequency neurotomy (Yin, W 2003); (3) lateral branch blocks (nerve blocks of the L4-5 primary dorsal rami and S1-S3 lateral branches) (Cohen, 2005); and (4) pulsed radiofrequency denervation (PRFD) of the medial branch of L4, the posterior rami of L5 and lateral branches of S1 and S2. (Vallejo, 2006) This latter study applied the technique to

patients with confirmatory block diagnosis of SI joint pain that did not have long-term relief from these diagnostic injections (22 patients)." ODG further states, "The use of all of these techniques has been questioned, in part, due to the fact that the innervation of the SI joint remains unclear. There is also controversy over the correct technique for radiofrequency denervation." RF ablation of SI joints is not recommended by ODG. The request is not medically necessary.

**Radiofrequency ablation of right SI joints:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation ODG Hip; and 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 (Acute and Chronic) chapter, Sacroiliac joint radiofrequency neurotomy

**Decision rationale:** This patient presents with bilateral SI joint pain with increasing complaints of pain in the bilateral lower extremities from the shins/calves to the bottom of the feet. The treater is requesting a radiofrequency ablation of the right SI joint. The ACOEM and MTUS guidelines do not discuss Radiofrequency ablation of the sacroiliac joints. ODG Guidelines, Hip and Pelvis (Acute and Chronic) chapter, has the following regarding Sacroiliac joint radiofrequency neurotomy, "Not recommended. Multiple techniques are currently described: (1) a bipolar system using radiofrequency probes (Ferrante, 2001); (2) sensory stimulation-guided sacral lateral branch radiofrequency neurotomy (Yin, W 2003); (3) lateral branch blocks (nerve blocks of the L4-5 primary dorsal rami and S1-S3 lateral branches) (Cohen, 2005); and (4) pulsed radiofrequency denervation (PRFD) of the medial branch of L4, the posterior rami of L5 and lateral branches of S1 and S2. (Vallejo, 2006) This latter study applied the technique to patients with confirmatory block diagnosis of SI joint pain that did not have long-term relief from these diagnostic injections (22 patients)." ODG further states, "The use of all of these techniques has been questioned, in part, due to the fact that the innervation of the SI joint remains unclear. There is also controversy over the correct technique for radiofrequency denervation." RF ablation of SI joints is not recommended by ODG. The request is not medically necessary.