

Case Number:	CM14-0033024		
Date Assigned:	04/23/2014	Date of Injury:	01/19/2011
Decision Date:	07/08/2014	UR Denial Date:	02/10/2014
Priority:	Standard	Application Received:	02/18/2014

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 Occupational 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 patient is a 53-year-old female who was injured on 01/19/2011. She was assisting other nurses and nurses' aides in moving and transporting clients when the patient began to note pain in the right side of the back and right leg. Prior treatment history has included Norco, Zanaflex, L4-L5, L5-S1 fusion(02/21/2013), and aquatic therapy. Primary treating physician's report dated 06/14/12, mentioned that the patient was seen for evaluation of constant low back pain and bilateral lower extremity symptoms. The listed diagnoses were; Fourth and fifth lumbar disc herniation with associated bilateral, but mostly right -sided sciatic radiculitis, lower extremity muscle weakness and lower back pain, which varied in intensity and required regular use of medication. Spinal adjustment with passive range of motion, lumbar myofascial stretching releases, and lumbar distraction to the herniated disc two times weekly for six weeks was recommended. Clinic visit note dated 11/20/2013 documented that the patient was still making some progress in the right direction. It was suggested that she finish a course of physical therapy over the next four to six weeks followed by which she will be released as permanent and stationary. During, the examination, one focal tenderness in the right sacroiliac (SI) joint was noted. A limited diagnostic ultrasound revealed that the articular cartilage was in good repair. There appeared to be some fluid within the sacroiliac joint consistent with a normal synovial joint. It was implied that this could represent some inflammatory fluid. Under ultrasonic technique, the needle was passed into the sacroiliac joint under sterile technique. The patient received an injection of the antiinflammatory medications without complication. The patient tolerated the procedure well and was without complication. [REDACTED] dated 11/25/2013, mentioned that the patient completed a total of 23 physical therapy treatments. Treatments consisted of an aquatic therapy program, which she tolerated very well. The patient felt better since therapy was initiated. She reported less pain while being in the pool.

Functionally, she reported walking was better, but still continued with difficulty sitting. Residual problems were pain in the low back and left lower extremity, limited with full functional activities. Recommendation was to continue with an aquatic therapy program two times a week for an additional four weeks. Follow up pain management note dated 12/23/2013 documented that the patient has been suffering from significant residual pain in her back with radiating symptoms to her leg despite having undergone successful lumbar fusion surgery. The patient underwent right SI (sacroiliac) joint injection which had helped her to alleviate her radiating symptoms. She still experienced the flare-up pain with repetitive activities or prolonged standing and walking. The current medication was helping her during her flare ups and was allowing to function with her daily activities. The patient rated the intensity of symptoms at 4 to 5 on a scale of 0-10 on average. Follow-up pain management note dated 01/27/2014 reports the patient was status post lumbar fusion. Overall, her condition was improving. The patient was concerned about her pain affecting her left buttock area. She previously had a great response to right sacroiliac joint injection and now would like to try left side. She continued to require medications on an as needed basis. She continued to find her regimen helpful except her Zanaflex, which did not help with her spasm. She rated her pain as 3-4/10 on an average. She was taking Vicodin 5/500 2 -3 times per day and Zanaflex 2 mg as needed. As the patient was stable at that time, she was instructed to continue on her pain medication management. Her most recent drug screening test was found to be appropriate. PR-2 dated 02/04/2014 documents a recommendation of pain management. On visit note dated 02/04/2014, the patient continues to have low back pain and reports the pain that radiates into her legs is worse at this time. She received an ultrasound-guided injection to the right SI joint which significantly improved her right leg pain; however, it is reported that she was experiencing more pain on the left side. She continued to receive her pain medicine from her pain management doctor. There is tenderness to palpation noted over the left SI joint. Straight leg raise test was positive on the left at 70 degrees. Motor examination is normal in all major muscle groups of the lower extremities. Her sensory examination was normal to light touch. The quadriceps reflexes were 1-2+ and symmetrical as well as the Achilles reflexes. The patient was instructed to receive pain medication from her management doctor and she was to return to work with restrictions. Permanent and stationary status report dated 02/21/2014 reports the patient presented to the office to discuss her condition. It was a rather lengthy discussion about the fact that she no longer needs to be treated by another physician in pain management, as certainly her volume of medication at this point in time was well within the comfort and was managing this matter as well. This would limit monthly visits to another doctor's office. The patient overall had done well with an anterior lumbar fusion. Prior UR dated 02/10/2014 states the request for pain management is partially certified to a routine follow-up as there is evidence justifying the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

PAIN MANAGEMENT: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 7, Independent Medical Examinations and Consultations, page 127.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 7, Independent Medical Examinations and Consultations, page 503 and Official Disability Guidelines (ODG), Hip and Pelvis, Sacroiliac Joint Blocks.

Decision rationale: As per ACOEM guidelines, consultation is recommended to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. The Official Disability Guideline (ODG) recommends that there should be evidence of a trial of aggressive conservative treatment (at least six weeks of comprehensive exercise program, local icing, mobilizing/manipulation and anti-inflammatories) as well as evidence of a clinical picture that is suggestive of sacroiliac (SI) injury and/or disease prior to a first SI joint block. A systematic review commissioned by the American Pain Society (APS) and conducted at the Oregon Evidence-Based Practice Center states that there is insufficient evidence to evaluate validity or utility of diagnostic sacroiliac joint block, and that there is insufficient evidence to adequately evaluate benefits of sacroiliac joint steroid injection. (Chou, 2009). Few of the many criteria for the use of sacroiliac blocks indicate that the history and physical should suggest the diagnosis of SI joint dysfunction (with the documentation of at least three positive exam findings listed below), diagnostic evaluation must first address any other possible pain generators and the patient has had and failed at least 4-6 weeks of aggressive conservative therapy including physical therapy (PT), home exercise and medication management. The medical records do not provide evidence of a clinical picture that would be suggestive of sacroiliac injury and/or disease prior to the first SI joint block that the patient received on 11/20/2013 for the right and on 02/04/2014 for the left. Further, it was documented that the patient underwent right SI (sacroiliac) joint injection, which had helped her to alleviate her radiating symptoms. She still experienced the flare-up pain with repetitive activities or prolonged standing and walking. The current medication was helping her during her flare-ups and was allowing functioning with her daily activities. The patient rated the intensity of symptoms at 4 to 5 on a scale of 0-10 on average. The medical records do not indicate that the patient had failed medical management prior to the ultrasound guided left SI joint injection. At that time the patient received the left SI joint injection, only tenderness to palpation over the left SI joint was noted. Specific tests for motion palpation and pain provocation were not described for SI joint dysfunction: Cranial Shear Test; Extension Test; Flamingo Test; Fortin Finger Test; Gaenslen's Test; Gillet's Test (One Legged-Stork Test); Patrick's Test (FABER); Pelvic Compression Test; Pelvic Distraction Test; Pelvic Rock Test; Resisted Abduction Test (REAB); Sacroiliac Shear Test; Standing Flexion Test; Seated Flexion Test; Thigh Thrust Test (POSH). Based on the Official Disability Guideline (ODG) and criteria as well as the clinical documentation stated above, the request for US guided left SI joint injection was not medically necessary. I concur with Prior UR dated 02/10/2014 opinion that the request for pain management would be appropriate and be partially certified to a routine follow-up as there is evidence justifying the request.