

<b>Case Number:</b>	CM14-0047745		
<b>Date Assigned:</b>	09/03/2014	<b>Date of Injury:</b>	08/06/2013
<b>Decision Date:</b>	09/29/2014	<b>UR Denial Date:</b>	03/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/16/2014

### 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 claimant injured his low back in a truck accident on 08/06/13. Bilateral L5-S1 facet injections and bilateral SI joint injections are under review. An MRI dated 10/02/13 revealed a left paracentral disc protrusion at L5-S1 affecting the exiting left S1 nerve root with neural foraminal narrowing and there was facet arthropathy. He was certified for a left S1 transforaminal epidural steroid injection. L5-S1 facet injections and SI joint injections were also non-certified. On 09/26/13, he reported multiple pains and stress. He had pain in the low back and both hips. He also had problems with his knees. He had multiple other complaints. He had various neurological type symptoms and headaches. Medications were not very helpful. He had stress and anxiety in the past. He was frequently groaning in pain. His neck movements were slightly limited by pain. Trunk movements were moderately limited by back pain. He was diagnosed with multiple contusions and strains and was not improving. He also had some deconditioning and postconcussion syndrome. He did not appear to be mentally fit to be at work. He was referred to a psychiatrist. He was given medications for pain and a walker. He attended physical therapy in September 2013. He had moderate to severe pain with simple range of motion. There was generalized weakness in his lower extremities. He saw [REDACTED] on 08/25/14 for an AME and had neurological symptoms including headaches. He was diagnosed with compression fractures and bulging disks in the cervical spine and compression fractures in the thoracic spine. He had ongoing pain despite PT for his neck and low back. His low back and mid back pain was constant. An epidural injection in the lumbar area gave him no relief. Physical examination of the low back revealed an antalgic gait and he was using a cane. He had some difficulty with tandem walk and difficulty standing on his heels and toes. He has been on multiple medications. He had extensive treatment. He had an MRI on 11/01/13 that showed degenerative disc disease at L4-5 and L5-S1. There was a small tear of the posterior annulus of

the L4-5 disc on the left and a small left paracentral disc osteophyte complex at L5-S1 slightly displacing but not entrapping the left S1 nerve root. He underwent a neuropsychological evaluation which indicated suboptimal effort and symptom exaggeration was noted by [REDACTED]. He did not have a surgical condition. He saw [REDACTED] on 03/18/14 and had pain across his back, bilateral hips, and left heel pain that extended up his leg to his back. He also had muscle cramping in the left leg and numbness and tingling in the entirety of his left arm and his left leg. He had giveaway strength in the left foot. There was mild limitation of lumbar range of motion. The sacrum was nontender. He had some nonspecific midline and paravertebral tenderness. Diagnoses included lumbar disc degeneration, thoracic or lumbosacral neuritis/radiculitis, radicular syndrome, lumbar spondylosis, and sciatica. Lumbar ESI, facet injections and SI joint injections were recommended. Electrodiagnostic studies on 05/22/14 showed no nerve conduction abnormalities but the EMG showed significant nerve damage and primarily S1 but possibly L5 lumbar nerve roots with very significant chronic changes and a surgical referral was recommended.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Bilateral Sacroiliac Joint Injections: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Hip and Pelvis Chapter, Sacroiliac Blocks.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, and Sacroiliac Injections.

**Decision rationale:** The history and documentation do not objectively support the request for bilateral sacroiliac injections at this time. The ODG state "sacroiliac joint injections are recommended as an option if failed at least 4-6 weeks of aggressive conservative therapy." In this case, there is not clear evidence of aggressive conservative therapy targeting the sacroiliac joints and no indication that the claimant has been involved in an ongoing independent program of exercise for his low back. The medical necessity of bilateral sacroiliac joint injections is not medically necessary.

#### **Bilateral Lumbar 5-Sacral 1 Facet Injections: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Low Back Chapter; Facet Joint Diagnostic Blocks (injections).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Facet Injections.

**Decision rationale:** The history and documentation do not objectively support the request for bilateral L5-s1 facet injections. The MTUS do not address facet injections and the ODG state "Criteria for the use of diagnostic blocks for facet "mediated" pain: Clinical presentation should be consistent with facet joint pain, signs & symptoms. 1. One set of diagnostic medial branch blocks is required with a response of 70%. The pain response should last at least 2 hours for Lidocaine. 2. Limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally. 3. There is documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks. 4. No more than 2 facet joint levels are injected in one session (see above for medial branch block levels). 5. Recommended volume of no more than 0.5 cc of injectate is given to each joint. 6. No pain medication from home should be taken for at least 4 hours prior to the diagnostic block and for 4 to 6 hours afterward. 7. Opioids should not be given as a "sedative" during the procedure. 8. The use of IV sedation (including other agents such as midazolam) may be grounds to negate the results of a diagnostic block, and should only be given in cases of extreme anxiety. 9. The patient should document pain relief with an instrument such as a VAS scale, emphasizing the importance of recording the maximum pain relief and maximum duration of pain. The patient should also keep medication use and activity logs to support subjective reports of better pain control. 10. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated. (Resnick, 2005) 11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. [Exclusion Criteria that would require UR physician review: Previous fusion at the targeted level. (Franklin, 2008)] In this case, the claimant's low back pain has been described as being radicular and due to radiculitis/radiculopathy. There were findings on the EMG of chronic nerve damage. He does not have solely axial pain. As a result, the medical necessity of this request has not been clearly demonstrated.