

<b>Case Number:</b>	CM14-0050903		
<b>Date Assigned:</b>	07/07/2014	<b>Date of Injury:</b>	04/22/2010
<b>Decision Date:</b>	08/21/2014	<b>UR Denial Date:</b>	04/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/18/2014

### 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 Orthopedic Surgery 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 injured worker is a 67-year-old female who reported an injury on 04/22/2010. The mechanism of injury was the injured worker was knocked over by a classroom of students running up to hug her. Prior treatments included aquatic therapy, physical therapy and transforaminal epidural steroid injections. The injured worker underwent a Computerized tomography (CT scan) of the lumbar spine post myelogram on 02/24/2013 which revealed that L4-L5 the disc cut was preserved. There was no disc herniation, spinal canal stenosis, lateral recess stenosis or neural foraminal narrowing. There was severe osteoarthritis of both facet joints. The ligamentum flavum measured 2 mm in thickness. The documentation of 03/07/2014 revealed the injured worker had a prior laminectomy at L4-L5 for a bulging disc in 1976. The documentation indicated the injured worker had 5 years of aquatic therapy. The back pain was noted to radiate down the bilateral greater trochanters. The injured worker underwent 5 sessions of physical therapy but did not notice an improvement so she stopped. Flexion and extension radiographs showed a loss of disc height at L5-S1 with a large anterior enthesophyte. There was no instability on flexion and extension. The diagnosis included, low back and bilateral leg pain. The treatment plan included bilateral sacroiliac joint injections and possible bilateral L4-L5 facet joint injections.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Bilateral sacroiliac joint injection:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip & Pelvis Chapter, Sacroiliac injection.

**Decision rationale:** The Official Disability Guidelines indicate the history and physical should suggest the diagnosis with at least 3 positive examination findings including, the cranial shear test, extension test, Flamingo test, Fortin finger test, Gaenslen's test, Gillet's test, Patrick's test, pelvic compression test, pelvic distraction test, pelvic rock test, resisted abduction test, sacroiliac shear test, standing flexion test, seated flexion test, or thigh thrust test. Additionally, the diagnostic evaluation must first address any other possible pain generators and there should be documentation the injured worker had and failed at least 4 to 6 weeks of aggressive conservative therapy including physical therapy, home exercise and medication management. The clinical documentation submitted for review failed to indicate the injured worker had at least 3 positive examination findings. Additionally, there was lack of documentation indicating the injured worker had failed 4 to 6 weeks of aggressive conservative therapy including physical therapy, home exercise and medication management. The clinical documentation indicated the injured worker had failed physical therapy. Given the above, the request for bilateral sacroiliac joint injection is not medically necessary.

**L4-5 Facet injection:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines - Low Back - Lumbar & Thoracic (Acute & Chronic) and Pain (Chronic).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Medial Branch Block.

**Decision rationale:** ACOEM Guidelines indicate that a facet neurotomy should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks. As ACOEM does not address medial branch diagnostic blocks, secondary guidelines were sought. Official Disability Guidelines indicate the criteria for the use of diagnostic blocks include the clinical presentation should be consistent with facet joint pain which includes tenderness to palpation at the paravertebral area, a normal sensory examination, absence of radicular findings although pain may radiate below the knee, and a normal straight leg raise exam. There should be documentation of failure of conservative treatment including home exercise, physical therapy, and non-steroidal anti-inflammatory drugs (NSAIDs) prior to the procedure for at least 4 to 6 weeks and no more than 2 facet joint levels should be injected in 1 session. Additionally, one set of diagnostic medial branch blocks is required with a response of 70%, and it is limited to no more than 2 levels bilaterally and they recommend no more than one set of medial branch diagnostic blocks prior to facet neurotomy, if neurotomy is chosen as an option for treatment (a procedure that is still considered under study). The clinical documentation

submitted for review failed to indicate the injured worker had a failure of home exercises and NSAIDS. Additionally, there was lack of documentation of tenderness to palpation in the paravertebral area, and normal sensory examination and the absence of radicular findings as well as a normal straight leg raise examination. Given the above, the request for L4-L5 facet injection is not medically necessary.