

Case Number:	CM14-0062079		
Date Assigned:	07/11/2014	Date of Injury:	04/13/2008
Decision Date:	09/08/2014	UR Denial Date:	04/22/2014
Priority:	Standard	Application Received:	05/05/2014

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:

This is a 49-year-old female with a 4/31/08 date of injury; the mechanism of the injury was not described. The patient was seen on 9/11/13 with complaints of constant and moderate low back pain with stiffness, tightness and severe muscle spasms. The pain radiated to the left lower extremity. The exam findings of the lumbosacral spine revealed no tenderness, minimal decrease in the range of motion and negative straight leg raising test bilaterally. The sensory examination was normal in all dermatomes of the lower extremities bilaterally and muscle strength was normal in all muscle groups bilaterally. The progress notes dated 11/6/13-4/3/14 stated that the patient complained of pain in the low back and hip. The physical examinations of the lumbosacral spine revealed skin incision at the midline, right and left lower lumbar tenderness, range of motion within normal limits in all planes with no pain, negative straight leg raise test bilaterally. The sensory examination was intact to touch and pin in L1-S5 dermatomes bilaterally. The motor strength was 5/5 in all muscle groups in the bilateral lower extremities and the reflexes were normal in the bilateral lower extremities. The patient was seen on 4/10/14 for the follow up visit. Exam findings revealed tenderness in the lower lumbar spine and negative straight leg test bilaterally. The range of motion, sensation and reflexes were within normal limits in the lumbar spine, SI region and bilateral lower extremities. Plain films of the lumbar spine were obtained and revealed that the fixation was excellent from L3-S1 and the disc above remained intact. The diagnosis is: status post anterior L3-L4 and L4-L5 lumbar discectomy and fusion, status post interbody fusion L5-S1 with posterolateral fusion L3-S1 and status post prior cervical fusion C3-C5, cervical spondylosis C6-C7. Treatment to date include anterior L3-L4 and L4-L5 lumbar discectomy and fusion, interbody fusion L5-S1 with posterolateral fusion L3-S1, cervical fusion C3-C5, cervical spondylosis C6-C7, work restrictions, physical therapy and

medications. An adverse determination was received on 4/22/14 given that the submitted report did not document exam findings consistent with the diagnosis of SI mediated pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left S1 Joint injection: 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): 309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (Hip and Pelvis Chapter, Sacroiliac joint injections).

Decision rationale: The California MTUS states that sacroiliac joint injections are of questionable merit. In addition, ODG criteria for SI joint injections include clinical sacroiliac joint dysfunction, failure of at least 4-6 weeks of aggressive conservative therapy, and the history and physical should suggest the diagnosis (with documentation of at least 3 positive exam findings). There is a lack of documentation indicating that the patient has subjective symptoms of SI joint dysfunction. In addition, the physical examination included in the progress notes dated 11/6/13-4/10/14 did not reveal any objective findings that would support that the patient suffered from SI joint dysfunction. The physical examination of the lumbosacral region revealed normal sensation in the L1-S5 dermatome distribution and 5/5 muscle strength in the bilateral lower extremities. In addition, the rationale for the request is not clear. Therefore, the request for Left S1 Joint injection was not medically necessary.