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| Case Number: | CM14-0065595 | | |
| Date Assigned: | 07/11/2014 | Date of Injury: | 06/07/2013 |
| Decision Date: | 11/20/2014 | UR Denial Date: | 04/23/2014 |
| Priority: | Standard | Application Received: | 05/08/2014 |

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 Preventive 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:

According to the records made available for review, this is a 32-year-old male with a 6/7/13 date of injury. At the time (4/8/14) of request for authorization for right sacroiliac joint and L5-S1 lumbar epidural steroid injection, there is documentation of subjective complaints include low back pain with left leg radiculopathy. The objective findings include tenderness over the left paraspinals and left hip and decreased range of motion. The imaging findings, MRI of the lumbar spine (10/21/13) report, revealed 3-4 mm left distal lateral recess; foraminal protrusion with partial annular tear which mildly flattens left anterolateral thecal sac without obvious impingement of the left L5 intrathecal nerve root; and mild to moderately narrows the left neural foramen which may affect the exiting left L4 nerve root within the left neural foramen at L4-L5. The current diagnoses include L4-5 disc bulge and left leg radiculopathy. The treatment to date is medications. Regarding sacroiliac injection, there is no documentation that the sacroiliac injection is not to be performed on the same day as the lumbar epidural steroid injection (ESI). Regarding lumbar epidural steroid injection, there is no specific (to a nerve root distribution) documentation of subjective (pain, numbness, and tingling) and objective (sensory, reflex, and motor changes) radicular findings in the requested nerve root distribution; and failure of additional conservative treatments (activity modification and physical modalities).

IMR ISSUES, DECISIONS AND RATIONALES

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

Right sacroiliac joint and L5-S1 lumbar epidural steroid injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), 2014, 19th Edition, Integrated Treatment./Disability Duration Guidelines, Hip and Pelvis (Acute and Chronic), Sacroiliac Joint Blocks

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300 and 309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip & Pelvis and Low Back Chapters, SI Joint Injection and Epidural Steroid Injections (ESIs)

Decision rationale: Specifically regarding sacroiliac joint injection, MTUS reference to ACOEM Guidelines identifies that invasive techniques are of questionable merit. Despite the fact that proof is still lacking, many pain physicians believe that diagnostic and/or therapeutic injections may have a benefit in patients presenting in the transitional phase between acute and chronic pain. Official Disability Guidelines (ODG) identifies documentation of at least >70% pain relief obtained for 6 weeks, that 2 months or longer have elapsed between each injection, and that the injection is not to be performed on the same day as a lumbar epidural steroid injection (ESI), transforaminal ESI, facet joint injection or medial branch block, as criteria necessary to support the medical necessity of repeat SI joint injection. Specifically regarding lumbar epidural steroid injection, MTUS reference to ACOEM guidelines identifies documentations of objective radiculopathy in an effort to avoid surgery as criteria necessary to support the medical necessity of epidural steroid injections. ODG identifies documentation of subjective (pain, numbness, or tingling in a correlating nerve root distribution) and objective (sensory changes, motor changes, or reflex changes (if reflex relevant to the associated level) in a correlating nerve root distribution) radicular findings in each of the requested nerve root distributions, imaging (MRI, CT, myelography, or CT myelography & x-ray) findings (nerve root compression OR moderate or greater central canal stenosis, lateral recess stenosis, or neural foraminal stenosis) at each of the requested levels, failure of conservative treatment (activity modification, medications, and physical modalities), and no more than two nerve root levels injected one session; as criteria necessary to support the medical necessity of lumbar epidural steroid injection. Within the medical information available for review, there is documentation of diagnoses of L4-5 disc bulge and left leg radiculopathy. In addition, there is documentation of imaging finding of moderate neural foraminal stenosis at the requested level. However, specifically regarding sacroiliac injection, given documentation of a request of right sacroiliac joint and L5-S1 lumbar epidural steroid injection, there is no documentation that the sacroiliac injection is not to be performed on the same day as the lumbar epidural steroid injection (ESI). In addition, specifically regarding lumbar epidural steroid injection, despite nonspecific documentation of subjective findings (low back pain with left leg radiculopathy), there is no specific (to a nerve root distribution) documentation of subjective complaints (pain, numbness, and tingling) and objective (sensory, reflex, and motor changes) radicular findings in the requested nerve root distribution. Furthermore, despite documentation of failure of conservative treatment (medications), there is no documentation of failure of additional conservative treatment.