

<b>Case Number:</b>	CM14-0198856		
<b>Date Assigned:</b>	12/09/2014	<b>Date of Injury:</b>	03/27/2008
<b>Decision Date:</b>	01/26/2015	<b>UR Denial Date:</b>	11/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/26/2014

### 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 Internal 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 injured worker (IW) is a 60-year-old woman with a date of injury of March 27, 2008. The mechanism of injury occurred when the IW was squatting down, and twisted to stand. The carrier has accepted the low back and the right hip. The current diagnoses are lumbar disc displacement; thoracic or lumbosacral neuritis or radiculitis, unspecified; degeneration of intervertebral disc; facet syndrome; sciatica; lumbar sprain/strain; contusion of finger; and contusion of unspecified body part. X-rays of the lumbar spine were performed January 11, 2013. The findings were stable degenerative change with degenerative disc disease as noted at L4-L5. The findings are unchanged from the June 2012 lumbar spine series. MRI of the lumbar spine dated May 3, 2013 demonstrates an approximate 3 mm in depth broad-based posterior disc bulge at L4-L5 results in inferior neural foraminal narrowing, more pronounced on the right, with contact made against the right L5 nerve root. Facet arthropathy present between L2-L3 through L5-S1 intervals. There is a 2 mm Grade I retrolisthesis defect of L4 relative to L5, which appeared attributable to facet arthropathy. Moderate to severe degenerative disc disease is present at L4-L5. Right laminectomy defect is present at L4-L5. Pursuant to the progress note dated November 10, 2014, the IW presents with back pain located in the midline area. Symptoms are described as throbbing, pressure and stabbing. The symptoms are alleviated by medications and walking. The symptoms started 6 years ago. Previous treatments have included surgery, injections and physical therapy. The IW has had several diagnostic injections ordered but she only received what she thinks may have been the SI joint and facet injection. Neither one did any good. Physical examination reveals moderate tenderness at the left lower lumbar paraspinal muscles and right lower lumbar paraspinal muscles over the bilateral facet joints at L4-L5, right SI joint, and right sided greater trochanter. Range of motion flexion is 75% of normal, lumbar extension is 25% of normal. Straight leg raise test in the sitting position is positive on the right.

Left facet loading (Kemp's test) is [positive. SI joint testing produces pain on the right side. The treating physician is requesting authorization for right hip injection, and right SI joint injection.

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

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

**Right hip injection:** 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 & Pelvis Chapter

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Hip and Pelvis Section, Intra-Articular Steroid Injection

**Decision rationale:** Pursuant to the Official Disability Guidelines, right hip injection is not medically necessary. Intra-articular steroid injection is not recommended early hip osteoarthritis. It is under study for moderately advanced or severe hip osteoarthritis, but if used, should be in conjunction with fluoroscopic guidance. It is recommended as an option for short-term pain relief in hip trochanteric bursitis. For additional details see the Official Disability Guidelines. In this case, the injured worker's working diagnoses are lumbar disc displacement; thoracic or lumbosacral neuritis or radiculopathy; facet syndrome; sciatica; lumbar strain/strain; contusion finger; and contusion of unspecified part (?). X-rays of the lumbar spine were performed on January 11, 2013. The findings were stable degenerative change with degenerative disc disease at L4 - L5. An MRI of the lumbar spine was performed May 3, 2013. It showed a 3 mm broad-based disc bulge at L4 - L5, more pronounced on the right contact against the right L5 nerve root; facet arthropathy between L2 - L3 and L5 - S1 intervals; 2 mm grade 1 retrolisthesis defect of L4 relative to L5; moderate degenerative disc disease L4 - L5 and right laminectomy defects at L4 - L5. There was no hip x-ray in the record. A progress note dated November 10, 2014 states the injured worker has had "several diagnostic injections order but she only received what she thinks may have been the SI joint and facet injections. Neither one did any good". There is no documentation in the medical record indicating the clinical rationale to perform an intra-articular steroid injection. There is no evidence of osteoarthritis, no hip or pelvis x-rays performed, and, according to a progress note dated November 10, 2014. the injured worker received what she thinks may have been an SI joint and facet injection, however, neither one did any good. The documentation is unclear as to exactly what type of injection was given. Consequently, absent the appropriate clinical indication and objective clinical findings, right hip injection is not medically necessary.

**Right SI joint injection:** 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 & Pelvis Chapter

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Hip and Pelvis Section, SI Joint Blocks

**Decision rationale:** Pursuant to the Official Disability Guidelines, right SI joint injection is not medically necessary. The Official Disability Guidelines enumerate the criteria for the use of sacroiliac blocks. The criteria include, but are not limited to, a history and physical examination that suggests the diagnosis; a positive diagnostic response is recorded as 80% for the duration of the local anesthetic. If the first block is not positive, a second diagnostic block is not performed. In this case, the injured worker's working diagnoses are lumbar disc displacement; thoracic or lumbosacral neuritis or radiculopathy; facet syndrome; sciatica; lumbar strain/strain; contusion finger; and contusion of unspecified part (?). X-rays of the lumbar spine were performed on January 11, 2013. The findings were stable degenerative change with degenerative disc disease at L4 - L5. An MRI of the lumbar spine was performed May 3, 2013. It showed a 3 mm broad-based disc bulge at L4 - L5, more pronounced on the right contact against the right L5 nerve root; facet arthropathy between L2 - L3 and L5 - S1 intervals; 2 mm grade 1 retrolisthesis defect of L4 relative to L5; moderate degenerative disc disease L4 - L5 and right laminectomy defects at L4 - L5. A progress note dated November 10, 2014 states the injured worker has had "several diagnostic injections order but she only received what she thinks may have been the SI joint and facet injections. Neither one did any good". There is no documentation in the medical record indicating the clinical rationale to perform an intra-articular steroid injection. There is no evidence of osteoarthritis, no hip or pelvis x-rays performed, and according to a progress note dated November 10, 2014 injured worker received what she thinks may have been an SI joint and facet injection, however, neither one did any good. The documentation is unclear as to exactly what type of injection was given, however, it appears the injured worker received an SI joint injection with no objective improvement. There is no evidence in the medical record the injured worker has sacroiliac generated pain. Consequently, absent a positive response to her prior SI joint injection, a right SI joint injection (repeat) is not medically necessary.