

Case Number:	CM14-0078617		
Date Assigned:	03/09/2015	Date of Injury:	12/18/1996
Decision Date:	04/13/2015	UR Denial Date:	05/16/2014
Priority:	Standard	Application Received:	05/29/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Texas, New York, California
 Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 applicant is a represented 67-year-old who has filed a claim for chronic low back pain reportedly associated with an industrial injury of December 18, 1996. Thus far, the applicant has been treated with the following: Analgesic medications; transfer of care to and from various providers in various specialties; earlier lumbar spine surgery; and various interventional spine procedures. On May 16, 2014, the claims administrator failed to approve requests for a sacroiliac joint injection and urine drug testing. The applicant's attorney subsequently appealed. On January 10, 2014, the applicant reported ongoing complaints of low back pain. The applicant was status post earlier sacroiliac joint injection therapy. The applicant was using OxyContin, oxycodone, tizanidine, and Lexapro, it was incidentally noted. The applicant was using a cane to move about. The applicant was described as having residual radicular pain complaints status post earlier failed spine surgery. Drug testing and topical compounds were endorsed.

IMR ISSUES, DECISIONS AND RATIONALES

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

DENERVATION OF LEFT SACROILIAC JOINT: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Hip and Pelvis (Acute & Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM V.3 Low Back Treatments Injection Therapies Sacroiliac Joint Injections. Recommendation: Sacroiliac Joint Corticosteroid Injections for Treatment of Sacroiliitis Sacroiliac joint corticosteroid injections are recommended as a treatment option for patients with a specific known cause of sacroiliitis, i.e., proven rheumatologic inflammatory arthritis involving the sacroiliac joints. Strength of Evidence? Recommended, Evidence (C) Recommendation: Sacroiliac Joint Injections for Treatment of Low Back Pain Sacroiliac joint injections are not recommended for treatment of acute low back pain including low back pain thought to be sacroiliac joint related; subacute or chronic non-specific low back pain, including pain attributed to the sacroiliac joints, but without evidence of inflammatory sacroiliitis (rheumatologic disease); or any radicular pain syndrome. Strength of Evidence? Not Recommended, Insufficient Evidence (I).

Decision rationale: No, the proposed denervation of left sacroiliac joint procedure was not medically necessary, medically appropriate, or indicated here. The MTUS does not address the topic. However, the Third Edition ACOEM Guidelines Low Back Chapter notes that sacroiliac joint injections should be reserved for applicants who have some rheumatologically-proven spondyloarthropathy implicating the SI joints. Here, however, there was no mention of the applicant's carrying a diagnosis of rheumatologically proven spondyloarthropathy implicating the SI joint. Rather, it appeared that the applicant's primary pain generator was residual lumbar radiculopathy following earlier failed lumbar spine surgery, a diagnosis for which sacroiliac joint injections are "not recommended," per ACOEM. It is further noted that the applicant has already seemingly had multiple SI joint injections, despite the unfavorable ACOEM position on the same and has, furthermore, failed to demonstrate any material benefit or functional improvement as defined in MTUS 9792.20f for the same. The applicant's work status was not clearly outlined on January 10, 2014, suggesting that the applicant was not, in fact, working. The applicant remained dependent on various opioid and nonopioid agents, including OxyContin, oxycodone, and Zanaflex. All of the foregoing, taken together, suggests a lack of functional improvement as defined in MTUS 9792.20f, despite receipt of prior SI joint injections. Therefore, the request was not medically necessary.

URINE DRUG SCREEN: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines May 2009 (Opiates steps to avoid misuse/addiction).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug testing Page(s): 43.

Decision rationale: Similarly, the urine drug screen was likewise not medically necessary, medically appropriate, or indicated here. While page 43 of the MTUS Chronic Pain Medical Treatment Guidelines does support intermittent drug testing in the chronic pain population, the

MTUS does not establish specific parameters for or identify a frequency with which to perform drug testing. ODG's Chronic Pain Chapter Urine Drug Testing topic, however, stipulates that an attending provider attempt to conform to the best practices of the United States Department of Transportation (DOT) when performing drug testing, further suggests that an attending provider eschew confirmatory and/or quantitative testing outside of the Emergency Drug drug overdose context, and finally, notes that an attending provider should attempt to categorize the applicants into higher- or lower-risk categories for which more or less frequent drug testing would be indicated. Here, the attending provider made no effort to categorize the applicant into higher- or lower-risk categories for which more or less frequent drug testing would be indicated. The attending provider did not clearly signal his intention to conform to the best practices of the United States Department of Transportation (DOT), nor did the attending provider signal his intention to eschew confirmatory and/or quantitative testing. The attending provider did not, furthermore, state which drug tests and/or drug panels he intended to test for. Since several ODG criteria for pursuit of drug testing were not met, the request was not medically necessary.