

Case Number:	CM15-0001705		
Date Assigned:	01/12/2015	Date of Injury:	02/25/2012
Decision Date:	03/10/2015	UR Denial Date:	12/24/2014
Priority:	Standard	Application Received:	01/05/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 patient is a 57-year-old female with an injury date of 02/25/12. Based on the 11/20/14 progress report provided by treating physician, the patient complains of severe low back pain which radiates to right groin and right lower extremity. Patient is status post lumbar transforaminal epidural steroid injection at the levels of L5 and S1 on the right side on 02/19/14 and L4-L5 decompression and fusion right side on 05/08/14. Physical examination to the lumbar area revealed significant tenderness over the right posterior-superior iliac spine, positive straight leg raise on the right side, and positive Patrick test on the right side. Gaenslen's test provoked the pain in the sacroiliac joint on the right side. Per PT evaluation report dated 05/22/14, the anticipated physical therapy time frame was reported as 4 weeks and per UR letter dated 12/24/14, the patient completed a total of 36 post-operative physical therapy treatments which resulted in improvement. Of note, per the progress report dated 11/20/14, the patient states that medications are helpful. Patient is temporarily totally disabled. EMG 10/16/14-There is no electrodiagnostic evidence of a peripheral neuropathy or lumbar radiculopathy. Diagnosis 11/20/14: Status post L4-L5 decompression and fusion right side on 05/08/14, Lumbar radiculopathy, Sacroiliac joint arthropathy right side. The utilization review determination being challenged is dated 12/24/14. The rationale follows: 1) 1 Right-Sided Sacroiliac Joint Block Under Fluoroscopic Guidance: the patient does not appear to be a candidate for the requested injection. 2) 1 Motorized Cold Therapy Unit For Purchase: the use of the unit is recommended

for post-operative symptoms of the knee or other extremity joints, for up to 7 days. Treatment reports were provided from 03/26/14 & 11/20/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Right Sided Sacroiliac Joint block under fluoroscopic guidance: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Hip & Pelvis

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Low Back Chapter under SI joint injections

Decision rationale: The patient presents with severe low back pain which radiates to right groin and right lower extremity. The request is for 1 RIGHT-SIDED SACROILIAC JOINT BLOCK UNDER FLUOROSCOPIC GUIDANCE. Physical examination to the lumbar area revealed significant tenderness over the right posterior-superior iliac spine, positive straight leg raise on the right side, and positive Patrick test on the right side. Gaenslen's test provoked the pain in the sacroiliac joint on the right side. Per PT evaluation report dated 05/22/14, the anticipated physical therapy time frame was reported as 4 weeks and per UR letter dated 12/24/14, the patient completed a total of 36 post-operative physical therapy treatments which resulted in improvement. Of note, per the progress report dated 11/20/14, the patient states that medications are helpful. Patient's diagnosis on 11/20/14 included lumbar radiculopathy and sacroiliac joint arthropathy right side. Patient is temporarily totally disabled. ODG guidelines, Low Back Chapter under SI joint injections states: " Treatment: There is limited research suggesting therapeutic blocks offer long-term effect. There should be evidence of a trial of aggressive conservative treatment (at least six weeks of a comprehensive exercise program, local icing, mobilization/manipulation and anti-inflammatories) as well as evidence of a clinical picture that is suggestive of sacroiliac injury and/or disease prior to a first SI joint block." ODG further states that, "The history and physical should suggest the diagnosis (with documentation of at least 3 positive exam findings as listed." Diagnosis: Specific tests for motion palpation and pain provocation have been described for SI joint dysfunction: Cranial Shear Test; Extension Test; Flamingo Test; Fortin Finger Test; Gaenslen's Test; Gillet's Test (One Legged-Stork Test); Patrick's Test (FABER); Pelvic Compression Test; Pelvic Distraction Test; Pelvic Rock Test; Resisted Abduction Test (REAB); Sacroiliac Shear Test; Standing Flexion Test; Seated Flexion Test; Thigh Thrust Test (POSH). Per treater report dated 11/20/14, patient is diagnosed with Sacroiliac joint arthropathy right side with two positive sacroiliac joint orthopedic tests; however, ODG guidelines require documentation of at least 3 positive exam findings. Furthermore, there is no documentation of at least 4-6 weeks failure of conservative care. On the contrary, UR letter dated 12/24/14 states that the patient has completed a total of 36 post-operative physical therapy treatments which resulted in improvement. Additionally, per the progress report dated 11/20/14, the patient also states that medications have been helpful, hence, the request does not meet guideline indications. Therefore, the request is IS NOT medically necessary.

1 Motorized Cold Therapy Unit for purchase: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Forearm, wrist, hand chapter under the Continuous cold therapy (CCT)

Decision rationale: The patient complains of severe low back pain which radiates to right groin and right lower extremity. The request is for 1 MOTORIZED COLD THERAPY UNIT FOR PURCHASE. MTUS and ACOEM do not discuss motorized cold therapy units. ODG online, Forearm, wrist, and hand section under the Continuous cold therapy (CCT) topic states: Recommended as an option only in the postoperative setting, with regular assessment to avoid frostbite. Treater has requested this unit for the prospective post sacroiliac joint injection. The patient is not in a postoperative setting and does not meet the ODG criteria for a motorized cold therapy unit. Therefore, the request IS NOT medically necessary.