

Case Number:	CM15-0004622		
Date Assigned:	01/15/2015	Date of Injury:	11/12/2010
Decision Date:	03/18/2015	UR Denial Date:	12/08/2014
Priority:	Standard	Application Received:	01/08/2015

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, Hawaii

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 injured worker is a male, who sustained an industrial injury on November 12, 2010. He has reported left lower back complaints and left sacroiliac joint pain. The diagnoses have included left lower back pain likely secondary to left sacroiliac joint irritation, left lumbosacral myofascial pain and anxiety. Treatment to date has included sacroiliac joint injections, pain management. Currently, the injured worker complains of low back pain, left sacroiliac joint pain, left anterolateral hip pain status post labral tear repair surgery. The injured worker was tender to palpation over the sacroiliac joint. A Patrick Test was positive on the left side. The pelvis distract with anteroposterior compression on ASIS was positive and compression pressure on the lateral side of the sacroiliac joint caused pain. The evaluating physician recommended a Sacroiliac steroid injection, motorized cold therapy unit for post-injection use, physical therapy and pain medication. On December 8, 2014 Utilization Review non-certified a request for left sacroiliac joint steroid injection under fluoroscopy and motorized cold therapy unit purchase, noting that there was no documentation of percent improvement or of corresponding decrease in pain medication related to previous injection and because the sacroiliac joint injection was not certified the post-injection treatment with the cold therapy unit was not certified. The MTUS was cited. On January 8, 2015, the injured worker submitted an application for IMR for review of left sacroiliac joint steroid injection under fluoroscopy and motorized cold therapy unit purchase.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left SI joint steroid injection under fluoroscopy: 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), Sacroiliac Joint Blocks Section, Web Edition

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Hip & Pelvis (Acute & Chronic) - Sacroiliac joint blocks

Decision rationale: The patient presents with left lower back complaints and left sacroiliac joint pain. The current request is for Left SI joint steroid injection under fluoroscopy. The treating physician states, "As the patient reports benefit from previous in-office left SI joint steroid injection and he had significant response to this injection under fluoroscopy, I am continuing to request authorization for left SI joint steroid injection under fluoroscopic guidance. The patient has undergone sacroiliac joint steroid injection several months ago with significant improvement in his pain. His pain gradually, after few months, came back." (123) The ODG guidelines state: In the treatment or therapeutic phase (after the stabilization is completed), the suggested frequency for repeat blocks is 2 months or longer between each injection, provided that at least >70% pain relief is obtained for 6 weeks. In this case, the treating physician has failed to document any percent improvement in pain from the time of the SI injection on 02/10/14 until the time of the present request. The ODG guidelines state repeat blocks are recommended only if there is greater than 70% improvement in pain relief for a six-week period of time. The documents provided only stated significant improvement which does not quantify 70% improvement. The current request is not medically necessary and the recommendation is for denial.

Motorized cold therapy unit: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Shoulder (Acute & Chronic) - Continuous-flow cryotherapy

Decision rationale: The patient presents with left lower back complaints and left sacroiliac joint pain. The current request is for Motorized cold therapy unit. The treating physician states, "I would like to order the following for the patient to be utilized post injection: Motorized Cold Therapy Unit for purchase only." (123) The ODG guidelines state: Recommended as an option after surgery, but not for nonsurgical treatment. In this case, the treating physician is proposing an injection, which has been deemed not medically necessary, and the patient has not received any recent surgery. The current request is not medically necessary and the recommendation is for denial.

