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| Case Number: | CM15-0004757 | | |
| Date Assigned: | 01/16/2015 | Date of Injury: | 11/15/2007 |
| Decision Date: | 03/16/2015 | UR Denial Date: | 12/19/2014 |
| Priority: | Standard | Application Received: | 01/09/2015 |

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: New York, Tennessee
 Certification(s)/Specialty: Emergency 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 injured worker is a 53 year old male, who sustained an industrial injury on 11/15/2007. He has reported lower back, neck, left hip, left femur, and both elbows. Magnetic Resonance Imaging (MRI) completed 11/23/2010 and 6/12/2013 revealed cervical fusion C3-C5 with instrumentation, degenerative changes L1-L4, and nerve root impingement L4-5. The IW underwent Open Reduction and Internal Fixation (ORIF) of left hip, with comminuted fracture of left femoral shaft, non-displaced fracture distal fibula, left ankle, patellar tendinitis, left knee, bilateral carpal tunnel syndrome. Fracture to right and left feet, and open fracture left femur. Treatment to date has included Non-Steroidal Anti-Inflammatory Drugs (NSAIDs), physical therapy, acupuncture, and home exercise. Currently, the IW complains of progressive limited range of motion to neck and bilateral arms associated with severe muscle spasm, numbness and tingling, headaches with blurry vision and pain; pain in the low back rating 9/10 VAS that is increasing in severity, and pain over left buttock that radiated to left lower extremity with numbness and tingling. Physical examination documented 12/23/2014, significant for severe sacroiliac joint inflammation with radiculopathy, positive Gaenslen's and Patrick Fabre tests. Diagnoses included lumbar sprain/strain, lumbar paraspinal muscle spasms/disc herniation, lumbar radiculopathy of lower extremities, sacroiliitis of left sacroiliac joint and cervical sprain/strain. On 12/19/2014 Utilization Review non-certified a injection-epidural lumbar transforaminal epidural steroid injection at L3-4, L4-5, on left, cervical spine injection, epidural at C7-T1 with catheter and C5-C7, steroid joint injection to left sacroiliac joint, noting documentation did not support recommended indication for the procedure and lack of prior

conservative treatment. The MTUS, ACOEM, and ODG Guidelines were cited. On 1/9/2015, the injured worker submitted an application for IMR for review of injection-epidural lumbar transforaminal epidural steroid injection at L3-4, L4-5, on left, cervical spine injection, epidural at C7-T1 with catheter and C5-C7, steroid joint injection to left sacroiliac joint.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar transforaminal epidural steroid injection at L3-L4 and L4-L5 on the left: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 46.

Decision rationale: Epidural steroid injections are recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. There is little information on improved function. The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months, and there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain. In this case documentation in the medical record does not support the presence of radicular pain and there is no corroboration by imaging or electrodiagnostic studies. Criteria for epidural steroid injections of the lumbar spine. The request should not be authorized.

Cervical epidural steroid injection at C7-T1 w/cath at C5-C7: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 175. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back Chapter and AMA Guides

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 46.

Decision rationale: Epidural steroid injections are recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). Most current guidelines recommend no more than 2 ESI injections. Current recommendations suggest a second epidural injection if partial success is produced with the first injection, and a third ESI is rarely recommended. Epidural steroid injection can offer short term

pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. There is little information on improved function. The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months, and there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain. The requested treatment is for ESI of the cervical spine. This is not recommended. The request should not be authorized.

Left sacroiliac joint injection: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 309. Decision based on Non-MTUS Citation Official Disability Guidelines, Hip & Pelvis Chapter

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Hip & Pelvis, sacroiliac joint blocks

Decision rationale: Sacroiliac joint blocks are recommended as an option if failed at least 4-6 weeks of aggressive conservative therapy as indicated below. Sacroiliac dysfunction is poorly defined and the diagnosis is often difficult to make due to the presence of other low back pathology (including spinal stenosis and facet arthropathy). The diagnosis is also difficult to make as pain symptoms may depend on the region of the SI joint that is involved (anterior, posterior, and/or extra-articular ligaments). Pain may radiate into the buttock, groin and entire ipsilateral lower limb, although if pain is present above L5, it is not thought to be from the SI joint. Etiology includes degenerative joint disease, joint laxity, and trauma (such as a fall to the buttock). The main cause is SI joint disruption from significant pelvic trauma. Specific tests for motion palpation and pain provocation have been described for SI joint dysfunction. These include 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, and Thigh Thrust Test (POSH). Imaging studies are not helpful. It has been questioned as to whether SI joint blocks are the "diagnostic gold standard." The block is felt to show low sensitivity, and discordance has been noted between two consecutive blocks (questioning validity). There is also concern that pain relief from diagnostic blocks may be confounded by infiltration of extra-articular ligaments, adjacent muscles, or sheaths of the nerve roots themselves. 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. If helpful, the blocks may be repeated; however, the frequency of these injections should be limited with attention placed on the comprehensive exercise program. Criteria for the use of sacroiliac blocks: 1. The history and physical should suggest the diagnosis (with documentation of at least 3 positive exam findings as listed above). 2. Diagnostic evaluation must first address any other possible pain generators. 3. The patient has had and failed at least 4-6 weeks of aggressive conservative therapy including PT, home exercise and medication management. 4. Blocks are performed under fluoroscopy. 5.

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. 6. If steroids are injected during the initial injection, the duration of pain relief should be at least 6 weeks with at least > 70% pain relief recorded for this period. 7. 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. 8. The block 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. 9. In the treatment or therapeutic phase, the interventional procedures should be repeated only as necessary judging by the medical necessity criteria, and these should be limited to a maximum of 4 times for local anesthetic and steroid blocks over a period of 1 year. Diagnosis of sacroiliac joint dysfunction is difficult to make due to the presence of other low back pathology. However invasive techniques are of questionable merit. In this case the request is made in addition to the requests for lumbar epidural steroid injections. The cause of the patient's pain is not clear. The procedure should not be considered until the diagnosis of sacroiliac disease is more certain. The request should not be authorized.