

Case Number:	CM15-0144944		
Date Assigned:	08/05/2015	Date of Injury:	02/07/2012
Decision Date:	09/02/2015	UR Denial Date:	06/25/2015
Priority:	Standard	Application Received:	07/27/2015

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, Indiana, New York
 Certification(s)/Specialty: Internal 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 41 year old male, who sustained an industrial injury on 2-7-12. He reported injury to his lower back. The injured worker was diagnosed as having lumbar disc prolapse with radiculopathy. Treatment to date has included physical therapy, a bilateral L4-L5 and L5-S1 epidural injection in 6-2014 and 4-22-15 with 75% improvement, acupuncture and aquatic therapy with no benefit. Current medications include Percocet, Soma, Terocin and Valium. On 4-27-15 the injured worker reported no leg pain following the epidural injection and he is able to walk further and bend with little to no pain. The PR2 on 5-18-15 indicated that the injured worker had begun to taper opioid medications and was following a home exercise program. As of the PR2 dated 6-15-15, the injured worker reports pain in his left and right buttock along with increased back pain. He went to acupuncture on his own with some relief. Objective findings include limited lumbar range of motion, an antalgic gait and a positive Faber exam. The treating physician requested a bilateral sacroiliac joint injection under MAC sedation and a pre-op baseline EKG.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral Sacroiliac (SI) Joint Injection under MAC sedation: Upheld

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

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, Sacroiliac joint injection.

Decision rationale: Pursuant to the Official Disability Guidelines, bilateral SI joint injections under MAC sedation are not medically necessary. The guidelines recommend the physical examination diagnostic criteria (see below) as a primary indication of pain related to the sacroiliac joint, with respect to sacroiliac pain, sacroiliac complex pain and sacroiliac dysfunction diagnostic signs and symptoms. Injections are not recommended for imaging studies for non-inflammatory pathology. Suggested physical examination indicators of pain related to the SI joint pathology include: history and physical should suggest the diagnosis. Pain may radiate into the buttock, groin and entire ipsilateral lower limb, although if pain is present above L5, it is generally not thought to be from the SI joint. There should be documentation of at least three positive exam findings to suggest the diagnosis. The five tests most recommended include pelvis distraction test, pelvic compression test, thigh thrust test, FABER (Patrick's test) and Gaensli's test. Diagnostic evaluation must first address any other possible pain generators. In this case, the injured worker's working diagnoses are lumbar disc prolapse with radiculopathy; and sacroiliitis. Subjectively, the injured worker complains of back pain that radiates to the buttocks and legs. Objectively, the right and left sacroiliac joint was painful. Straight leg raising was positive. Gait was antalgic. There was moderate lumbar spasm and tenderness to palpation over the lumbar paraspinal muscle groups. There is pain with range of motion. The diagnostic evaluation should evaluate other possible pain generators. Injured worker had a good response to the transforaminal epidural steroid injection provided. There is no documentation the injured worker had aggressive physical therapy to the sacroiliac joint with failure of physical therapy. The documentation shows the injured worker had a few sessions of physical therapy, but ongoing physical therapy was not approved. Aggressive physical therapy is indicated to address other pain generators. Consequently absent clinical documentation with a full course of physical therapy to address other pain generators, bilateral SI joint injections under MAC sedation are not medically necessary.

Pre-op baseline EKG: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.aafp.org/afp/2013/0315/p414.html>.

Decision rationale: Pursuant to the American Family Physician, preoperative baseline EKG is not medically necessary. Preoperative testing (e.g., chest radiography, electrocardiography, laboratory testing, and urinalysis) is often performed before surgical procedures. These investigations can be helpful to stratify risk, direct anesthetic choices, and guide postoperative management, but often are obtained because of protocol rather than medical necessity. The

decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. Patients with signs or symptoms of active cardiovascular disease should be evaluated with appropriate testing, regardless of their preoperative status. Electrocardiography is recommended for patients undergoing high-risk surgery and those undergoing intermediate-risk surgery who have additional risk factors. Patients undergoing low-risk surgery do not require electrocardiography. In this case, the injured worker's working diagnoses are lumbar disc prolapse with radiculopathy; and sacroiliitis. Subjectively, the injured worker complains of back pain that radiates to the buttocks and legs. Objectively, the right and left sacroiliac joint was painful. Straight leg raising was positive. Gait was antalgic. There was moderate lumbar spasm and tenderness to palpation over the lumbar paraspinal muscle groups. There is pain with range of motion. In this case, the injured worker's working diagnoses are lumbar disc prolapse with radiculopathy; and sacroiliitis. Subjectively, the injured worker complains of back pain that radiates to the buttocks and legs. Objectively, the right and left sacroiliac joint was painful. Straight leg raising was positive. Gait was antalgic. There was moderate lumbar spasm and tenderness to palpation over the lumbar paraspinal muscle groups. There is pain with range of motion. Patients undergoing low-risk surgery do not require electrocardiography. SI joint injections are a low risk procedure and do not require electrocardiography. Additionally, SI joint injections are not clinically indicated and, as a result, a preoperative baseline EKG is not clinically indicated. Based on the clinical information in the medical record and the peer-reviewed evidence-based guidelines, preoperative baseline EKG is not medically necessary.