

Case Number:	CM15-0191189		
Date Assigned:	10/05/2015	Date of Injury:	12/31/2005
Decision Date:	11/10/2015	UR Denial Date:	09/01/2015
Priority:	Standard	Application Received:	09/29/2015

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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 54 year old male who sustained an industrial injury December 31, 2005. Past history included status post L3-L5 decompression with interbody and posterolateral fusion March 17, 2008 and status post hardware removal with re-fusion L4-5 and L5-S1 October 24, 2009. According to a physician's follow-up evaluation dated August 18, 2015, the injured worker has been tolerating conversion to MS Contin well with pain levels of 5 out of 10 to the lower back. He has decreased Gabapentin intake to 300 mg twice a day and needs a refill of Celebrex. He reports wanting to be considered for a radiofrequency neurotomy. Physical examination revealed; lumbar exam-tenderness to palpation at and below the iliac crest level on the right; lumbar extension more painful than flexion and no pain with rotation; straight leg raise negative; Patrick's maneuver was minimally positive on the right and negative on the left; Yeoman's positive on the right; manual muscle testing demonstrated 5 out of 5 strength in the lower extremity; sensory exam intact in the lower extremity; gait within normal limits. The physician documented the injured worker demonstrated one day of pain relief after a sacroiliac joint injection under fluoroscopy October 22, 2014 and also demonstrated improvement after physical therapy in the past (unspecified). Impressions are documented as axial low back pain, primarily right side; chronic pain with high dose opioid usage for pain management. Treatment plan included continued MS Contin, change Oxycodone to Morphine Sulfate Immediate Release for two weeks, and refill Celebrex. At issue, is the request for authorization for right S1, S2, S3 lateral branch block with Lidocaine. A report of an MRI of the lumbar spine dated January 28, 2013, is present in the medical record. According to utilization review dated September 1, 2015, the request for Right S1, S2, and S3 Lateral Branch Block with Lidocaine is non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right S1, S2, S3 Lateral Branch Block with Lidocaine: 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) web, 2015. Hip and Pelvis Chapter, Sacroiliac injections, Diagnostic.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (1) Hip & Pelvis (Acute & Chronic) Sacroiliac joint blocks (2) Hip & Pelvis (Acute & Chronic), Sacroiliac joint radiofrequency neurotomy.

Decision rationale: The claimant has a remote history of a work injury occurring in December 2005 with treatment including a multilevel lumbar fusion in March 2008 with subsequent hardware removal and revision fusion surgery in October 2009 due to a pseudoarthrosis. Bilateral intra-articular sacroiliac joint injections were done in October 2014. In January 2015, there had been one day of improvement after the injection. When seen, he was tolerating conversion to MS Contin well. He had pain rated at 5/10. He had discussed a "burning procedure of the nerves" with a friend and was interested in being considered for the procedure. Physical examination findings included minimally positive right Patrick's testing. Yeoman's testing was positive on the right side. He had normal gait. Authorization was requested for a right sacroiliac blocks to determine whether he would be a candidate for a radiofrequency ablation procedure. Criteria for the use of sacroiliac blocks include a history of and physical examination findings consistent with a diagnosis of sacroiliac joint pain and after failure of conservative treatments. Requirements include the documentation of at least three positive physical examination findings. In this case, the requesting provider documents only two positive right sacroiliac joint tests. The claimant's response to the intra-articular injections performed in October 2014 is not adequately described and should have already provided an adequate diagnostic test for sacroiliac joint mediated pain. The purpose of the block now being requested is to determine whether radiofrequency ablation would be performed, and sacroiliac joint radiofrequency neurotomy is not recommended. For any of these reasons, the request is not medically necessary.