

Case Number:	CM15-0200047		
Date Assigned:	10/15/2015	Date of Injury:	08/19/2006
Decision Date:	12/18/2015	UR Denial Date:	10/02/2015
Priority:	Standard	Application Received:	10/12/2015

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, California 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:

This is a 58 year old female with a date of injury of August 19, 2006. A review of the medical records indicates that the injured worker is undergoing treatment for bilateral sacroiliitis, lumbar spine sprain and strain, lumbar paraspinal muscle spasms, and chronic pain. Medical records dated August 12, 2015 indicate that the injured worker complained of bilateral buttock pain radiating to the posterior and lateral aspect of the thighs with numbness and tingling progressively increasing in severity. A progress note dated September 23, 2015 documented complaints similar to those reported on August 12, 2015, with the addition of complaints of lower back pain and limited range of motion of the lumbar spine with associated severe muscle spasms, and pain radiating to the legs. The physical exam dated August 12, 2015 reveals bilateral sacroiliac joint inflammation, positive Gaenslen's and Patrick Fabre test, and severely positive sacroiliac joint thrust. The progress note dated September 23, 2015 documented a physical examination that showed tenderness to the bilateral lumbar paravertebral muscles and bilateral sacroiliac joint, marked stiffness of the bilateral hips and knees, severe guarding to deep palpation on the bilateral lower extremities associated with severe myofascial pain, pain over the spinous processes with guarding, decreased range of motion of the lumbar spine, positive straight leg raising test bilaterally, decreased motor strength of the bilateral lower extremities, positive facet joint thrust test bilaterally, positive facet loading test bilaterally, positive Patrick Fabre test and Bragard test bilaterally, positive Trendelenburg test and Lasegue test bilaterally, positive sciatic tenderness bilaterally, and positive Gaenslen's sign bilaterally. Treatment has included right sacroiliac joint injection (March 4, 2015) and left sacroiliac joint injection (March 18, 2015) with 50% improvement in weakness, tingling, and numbness in the bilateral

lower legs lasting for six weeks, and medications (Flurbiprofen compound cream). There was no documentation of previous imaging studies in the submitted records. The original utilization review (October 2, 2015) non-certified a request for a second bilateral sacroiliac joint injection under fluoroscopic guidance, lumbar spine magnetic resonance imaging, urine drug screen, and P-Stim once a week for four weeks for the lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

2nd Bilateral SI joint injection under fluoroscopic guidance: 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), Hip and Pelvis Chapter, Intra-articular steroid hip injection (IASHI), Sacroiliac joint blocks.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back - sacroiliac joint injection.

Decision rationale: Ca MTUS is silent on this topic. The ODG guidelines cited above state this procedure is "not recommended except as a last resort for chronic or severe sacroiliac joint pain." Further guidelines review criteria for the use of sacroiliac blocks. These guidelines include a requirement for a minimum of 3 positive exam findings to 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; Thigh Thrust Test (POSH)" The IW does have documentation of some of these findings. The IW has previous undergone SI injections. There is report of pain improvement following the injection, but there is no documentation of functional improvement following the procedure. Finally, the request does not discuss what substance is being injected. It is unclear if the injectate is intended to be a steroid, anti-inflammatory, or an analgesic. Without this supporting documentation, the request for right SI joint injection with fluoroscopy is not medically necessary.

Lumbar spine MRI: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Examination, Diagnostic Criteria, Special Studies.

Decision rationale: CA MTUS ACOEM guidelines recommends imaging studies for cases "in which surgery is considered or red-flag diagnoses are being evaluated." ODG guidelines state "repeat MRI is not routinely recommended and should be reserved for a significant change in

symptoms and/or findings suggestive of significant pathology." Documentation does not support significant changes in subjective complaints of objective findings. There is not documentation of new injuries or adjustments to analgesic medication. A lumbar MRI was request in February 2015. It is unclear from the documentation if this study was completed. There is no mention of surgeon evaluation or treatment. The request for a lumbar MRI is not medically necessary.

Urine drug test: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, screening for risk of addiction (tests).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, dealing with misuse & addiction, Opioids, screening for risk of addiction (tests).

Decision rationale: Medical necessity for a urine drug screen is predicated on a chronic opioid therapy program conducted in accordance with the recommendations of the MTUS, or for a few other, very specific clinical reasons. There is no evidence in this case that opioids are prescribed according to the criteria outlined in the MTUS. The treating physician has not listed any specific reasons to conduct the urine drug screen. There is no documentation of previous test results. The collection procedure was not specified. The MTUS recommends random drug testing, not at office visits. The treating physician has not discussed the presence of any actual random testing. The details of testing have not been provided. Potential problems with drug tests include: variable quality control, forensically invalid methods of collection and testing, lack of random testing, lack of MRO involvement, unnecessary testing, and improper utilization of test results. The specific content of the test should be listed, as many drug tests do not assay the correct drugs. The urine drug screen is not medically necessary based on lack of a clear collection and testing protocol, lack of details regarding the testing content and protocol, and lack of a current opioid therapy program which is in accordance with the MTUS.

P-Stim x4, once a week for 4 weeks for the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Percutaneous electrical nerve stimulation (PENS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Percutaneous electrical nerve stimulation (PENS).

Decision rationale: According the above CaMTUS guidelines, percutaneous electrical nerve stimulation is "Not recommended as a primary treatment modality, but a trial may be considered, if used as an adjunct to a program of evidence-based functional restoration, after other non-surgical treatments, including therapeutic exercise and TENS, have been tried and failed or are judged to be unsuitable or contraindicated. There is a lack of high quality evidence to prove long-term efficacy." The submitted documentation does not support the IW has trialed a TENS unit. There is no documentation of non-surgical treatments such as physical therapy, chiropractic care, or a home exercise program. Without the support of the documentation or adherence to the guidelines, the request for PENS treatment is determined not medically necessary.