

Case Number:	CM15-0210059		
Date Assigned:	10/29/2015	Date of Injury:	03/30/2011
Decision Date:	12/11/2015	UR Denial Date:	10/09/2015
Priority:	Standard	Application Received:	10/26/2015

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

Certification(s)/Specialty: Preventive Medicine, Occupational 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 injured worker is a 73 year old female, who sustained an industrial injury on 03-30-2011. The injured worker was diagnosed as having chronic low back pain, sacroilitis, and lumbosacral spondylosis and right knee pain. On medical records dated 08-19-2015 and 09-16-2015, the subjective complaints were noted as back pain and decreased. Pain was rated 8 out of 10. Pain was located in the low back and right sacroiliac region. Objective findings were noted a lumbosacral spine revealed tenderness to paravertebral muscle L3-S1 with surrounding tissue tension-texture as soft and spasm. Pain was noted as severe, constant ache and deep. Location of pain was noted as bilaterally to hips and lower back bilaterally. Right knee tenderness was noted at medial aspect. Treatments to date included medication. Current medications were listed as Voltaren Gel, Tramadol, Ibuprofen and Lyrica. The Utilization Review (UR) was dated 10-09-2015. A Request for Authorization was dated 10-058-2015. The UR submitted for this medical review indicated that the request for right sacroiliac joint injection times 1 and Voltaren Gel 1% 2g was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right sacroiliac joint injection x 1: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, SI Blocks.

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 Chapter/Sacroiliac Joint Blocks Section.

Decision rationale: The MTUS Guidelines do not address the use of sacroiliac joint injections. The ODG recommends sacroiliac joint blocks as an option if the injured worker has failed at least 4-6 weeks of aggressive conservative therapy. The criteria for the use of sacroiliac blocks include; 1) History and physical should suggest the diagnosis with documentation of at least 3 positive exam findings. 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 physical therapy, 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, and 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 phase the suggested frequency for repeat blocks is 2 months or longer 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, transforaminal epidural steroid injection, facet joint injection or medial branch block. 9) In treatment phase the interventional procedures should be repeated only as necessary judging by the medical necessity criteria and should be limited to a maximum of 4 times for local anesthetic and steroid blocks over a period of 1 year. In this case, objective findings of the lumbosacral spine revealed tenderness to paravertebral muscle L3-S1 with surrounding tissue with spasm. Pain was noted as severe, constant ache and deep. Location of pain was noted as bilaterally to hips and lower back bilaterally. An SI joint injection is reasonable in this case. The request for right sacroiliac joint injection x 1 is determined to be medically necessary.

Voltaren Gel 1% 2 grams, 1 tube: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Voltaren Gel.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: Per the MTUS Guidelines, the use of topical analgesics is recommended as an option for some agents. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. When investigated specifically for osteoarthritis of the knee, topical NSAIDs have been shown to be superior to placebo for 4 to 12 weeks. Voltaren Gel 1% is FDA approved and indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. Maximum dose should not exceed 32g per day (8g per joint per day in the upper extremity and 16g per joint per day in the lower extremity). In this case, the medication is intended for use with the spine, which is not supported. The request for Voltaren Gel 1% 2 grams, 1 tube is determined to not be medically necessary.