

<b>Case Number:</b>	CM15-0059524		
<b>Date Assigned:</b>	04/06/2015	<b>Date of Injury:</b>	03/06/1995
<b>Decision Date:</b>	05/05/2015	<b>UR Denial Date:</b>	03/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/30/2015

### 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: Ohio, North Carolina, Virginia  
Certification(s)/Specialty: Family Practice

### 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 was a 68-year-old female, who sustained an industrial injury, March 6, 1995. The injured worker suffered a fall and slip rupturing a disc in the lumbar spine and cervical spine. The injured worker had postoperative complications and ended up with a neurogenic bladder and dystonia from Haldol. The injured worker previously received the following treatments psychiatric evaluation, laboratory studies, Ibuprofen, lumbar spine MRI, EMG/NCS (electrodiagnostic studies and nerve conduction studies) and physical therapy. The injured worker was diagnosed with bi-polar disorder, sacroiliac joint arthropathy, facet arthropathy, lumbar arachnoiditis, failed back surgery, dystonia of the hands and neurogenic bladder. According to progress note of March 3, 2015, the injured workers chief complaint was low back pain. The injured worker described the pain as throbbing, aching, sharp, burning and continuous. The pain was aggravated by standing or sitting for more than 10-20 minutes, walking, bending. The pain was slightly relieved by lying down and taking Ibuprofen. The physical exam noted positive straight leg rising on the left. The Patrick's test was positive on the left. There was pain with hyperextension of the back and axial loading. The treatment plan included bilateral sacroiliac joint injections and vitamin D 50,000 units per week for 4 weeks for pain.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Bilateral sacroiliac joint injection QTY: 2.00: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines. Hip and Pelvis chapter. Sacroiliac joint blocks section.

**Decision rationale:** On 3-3-2015, the treating physician documented a physical exam showing a positive straight leg raise test on the left, a positive Patrick's test on the left, and pain with hyperextension of the back and axial loading of the back. On that basis, the physician requested bilateral sacroiliac joint injections. Physical exam findings consistent with sacroiliac joint pain include: the 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). 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). (Schwarzer, 1995) 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. Sacral lateral branch injections have demonstrated a lack of diagnostic power and area not endorsed for this purpose. 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. (Hansen, 2003) 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. In this instance, 3 positive exam findings consistent with sacroiliac joint pain are not present for the left and the right sacroiliac joint. Therefore, bilateral sacroiliac joint injections are not medically necessary.

**Vitamin D 50,000 units/week QTY:4.00: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines. Pain (Chronic) chapter. Vitamin D (cholecalciferol) section.

**Decision rationale:** Vitamin D is not recommended for the treatment of chronic pain based on recent research. Although it is not recommended as an isolated pain treatment, vitamin D supplementation is recommended to supplement a documented vitamin deficiency, which is not generally considered a workers' compensation condition. Musculoskeletal pain is associated with low vitamin D levels but the relationship may be explained by physical inactivity and/or other confounding factors. Adjusting for these factors attenuated the relationship, although pain remained moderately associated with increased odds of 20% of having low vitamin D levels. (McBeth, 2010) Inadequate vitamin D may represent an under-recognized source of nociperception and impaired neuromuscular functioning among patients with chronic pain. Physicians who care for patients with chronic, diffuse pain that seems musculoskeletal - and involves many areas of tenderness to palpation - should consider checking vitamin D level. For example, many patients who have been labeled with fibromyalgia may be suffering from symptomatic vitamin D inadequacy. There is also a correlation between inadequate vitamin D levels and the amount of narcotic medication taken by chronic pain patients. Patients with inadequate vitamin D may benefit from cholecalciferol 50,000 international units dosed according to the level of deficiency, but caution is necessary for patients with calcium- or phosphate- processing disorders because increasing vitamin D levels could be problematic in patients with kidney failure or stones or primary hyperparathyroidism or sarcoidosis. In this instance, the treating physician recommended 50,000 units/week of Vitamin D for 4 weeks per the note of 3-3-2015. The rationale provided was the known association between chronic pain and steroid use with low Vitamin D levels. The guidelines, however, require documentation of a low Vitamin D level for its approved use. A review of the submitted medical record does not reveal documentation of any measurements of Vitamin D. Therefore, Vitamin D 50,000 units/week QTY:4.00 is not medically necessary per the referenced guidelines and in view of the available medical record.