

Case Number:	CM14-0148613		
Date Assigned:	09/18/2014	Date of Injury:	11/07/2013
Decision Date:	10/16/2014	UR Denial Date:	08/14/2014
Priority:	Standard	Application Received:	09/12/2014

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. The expert reviewer is Board Certified in Internal Medicine, has a subspecialty in Nephrology and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 35-year-old female who has submitted a claim for lumbar degenerative disc disease and sacroiliitis associated with an industrial injury date of 11/07/2013. Medical records from 12/05/2013 to 07/25/2014 were reviewed and showed that patient complained of low back pain graded 3-8/10. There was complaint of heartburn. Physical examination revealed tenderness over midline of lower lumbar spine and left sacroiliac joint, decreased lumbar ROM, weakness of left lower extremity, intact sensation of lower extremities, decreased patellar DTRs bilaterally, and positive FABER test. MRI of the lumbar spine dated 04/03/2014 revealed L4-5 bilateral lateral recess stenosis and L5-S1 bilateral pars defect with spondylolisthesis. Treatment to date has included left SI joint injection (12/19/2013), physical therapy, heat/cold pack application, Voltaren gel 1% (prescribed 07/25/2014), and pain medications. Of note, there was documentation of some relief for unspecified duration with left sacroiliac joint injection. The patient reported pain relief with physical therapy (12/05/2013). Utilization review dated 08/14/2014 denied the request for left sacroiliac joint injection because there was no documentation of positive response from previous injection. Utilization review dated 08/14/2014 denied the request for Voltaren gel 1% tube because alternative analgesics and non-pharmacologic therapy should be considered.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left sacroiliac joint injection: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Hip and pelvis Chapter, 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) Hip and Pelvis, Sacroiliac Joint Blocks

Decision rationale: According to page 309 of the ACOEM Guidelines referenced by CA MTUS, sacroiliac joint injections are of questionable merit. Despite the fact that proof is still lacking, many pain physicians believe that injections may have a benefit in patients presenting in the transitional phase between acute and chronic pain. Official Disability Guidelines criteria for SI joint injections include: clinical sacroiliac joint dysfunction; failure of at least 4-6 weeks of aggressive conservative therapy; history and physical exam should suggest the diagnosis (with documentation of at least 3 positive exam findings); and 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. In this case, the patient had previous left sacroiliac joint injection on 12/19/2013 that provided some pain relief for unspecified duration. The guidelines only recommend repeat block for sustained pain relief >70% of 6 weeks duration. Moreover, physical exam did not include 3 positive findings to support diagnosis. Therefore, the request for left sacroiliac joint injection is not medically necessary.

Voltaren gel 1%, 1 tube: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Diclofenac (Voltaren). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Diclofenac

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

Decision rationale: According to CA MTUS Chronic Pain Treatment Guidelines, topical NSAIDs are recommended for osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment. There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. It is recommended for short-term use (4-12 weeks). In this case, the patient was prescribed Voltaren 1% gel since 07/25/2014 to address low back pain. However, there is little evidence for the use of topical NSAIDs for the spine. Moreover, topical NSAIDs are only recommended for short-term use per guidelines recommendation. There is no discussion as to why variance from the guidelines is needed. Therefore, the request for Voltaren gel 1%, 1 tube is not medically necessary.