

<b>Case Number:</b>	CM14-0088051		
<b>Date Assigned:</b>	08/08/2014	<b>Date of Injury:</b>	02/15/1992
<b>Decision Date:</b>	09/22/2015	<b>UR Denial Date:</b>	05/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/11/2014

### 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. 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: Orthopedic Surgery

### 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 73 year old male with an industrial injury dated 02/15/1992. The injured worker's diagnoses include post laminectomy lumbar syndrome and post laminectomy cervical syndrome. Treatment consisted of diagnostic studies, prescribed medications, lumbar epidural steroid injection (ESI) on 12/3/2013 and periodic follow up visits. In a progress note dated 04/15/2014, the injured worker reported neck and lower back pain with lateral radiation across his low back to bilateral buttocks. The injured worker also reported radiation into the left anterior thigh with numbness. The injured worker rated pain a 7/10. Objective findings revealed limited range of motion and tenderness to palpitation over the bilateral sacroiliac (SI) joints. The treating physician prescribed services for one bilateral sacroiliac joint Injection, Fluoroscopic Guidance, one arthrogram, IV Sedation, Percocet 5/325mg, #30, Topamax 50mg, #60 with 3 refills, and Flexeril 10mg, #60 with 3 refills now under review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 Bilateral Sacroiliac Joint Injection: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Hip & Pelvis (Acute & Chronic), 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:** CA MTUS/ACOEM is silent on the issue of sacroiliac joint injection. According to the ODG Hip and Pelvis, Sacroiliac joint blocks it is recommended as an option if 4-6 weeks of aggressive conservative therapy has been failed. In addition there must be at least 3 positive exam findings such as a pelvic compression test, Patrick's test and pelvic rock test. In this case there is no evidence of aggressive conservative therapy being performed or 3 positive SI joint findings prior to the request for the sacroiliac joint injection on 4/15/14. Therefore the guideline criteria have not been met and the request is not medically necessary.

**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, Hip & Pelvis.

**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:** As the requested sacroiliac joint injection is not medically necessary, none of the associated services are medically necessary and appropriate

**1 arthrogram:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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:** As the requested sacroiliac joint injection is not medically necessary, none of the associated services are medically necessary and appropriate

**IV Sedation:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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:** As the requested sacroiliac joint injection is not medically necessary, none of the associated services are medically necessary and appropriate.

**Percocet 5/325mg, #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 80.

**Decision rationale:** According to the CA MTUS/Chronic Pain Medical Treatment Guidelines, page 80, opioids should be continued if the patient has returned to work and the patient has improved functioning and pain. Based upon the records reviewed there is insufficient evidence to support chronic use of narcotics. There is lack of demonstrated functional improvement, percentage of relief, demonstration of urine toxicology compliance or increase in activity from the exam note of 4/15/14. Therefore the request is not medically necessary.

**Topamax 50mg, #60 with 3 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topiramate Page(s): 21.

**Decision rationale:** Per the CA MTUS Chronic Pain Treatment Guidelines page 21, Specific Anti-Epilepsy Drugs, Topiramate is indicated for neuropathic pain of central etiology and when other anticonvulsants fail. In this case, the exam note from 4/15/14 does not demonstrate evidence neuropathic pain or demonstrate percentage of relief, the duration of relief, increase in function or increased activity. There is no documentation of failed first line anti-epilepsy drugs such as Neurontin. Therefore medical necessity has not been established, and the request is not medically necessary.

**Flexeril 10mg, #60 with 3 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 41-42.

**Decision rationale:** According to the CA MTUS, Chronic Pain Medical Treatment Guidelines, Cyclobenzaprine, pages 41-42, Flexeril is recommended as an option, using a short course of therapy. Cyclobenzaprine (Flexeril) is more effective than placebo in the management of back pain; the effect is modest and comes at the price of greater adverse effects. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. (Browning, 2001). Treatment should be brief. There is also a post-op use. The addition of Cyclobenzaprine to other agents is not recommended. In this particular case the patient has no evidence in the records of 4/15/14 of functional improvement, a quantitative assessment on how this medication helps, percentage of relief lasts, increase in function, or increase in activity. Therefore chronic usage is not supported by the guidelines. Therefore the request is not medically necessary.