

Case Number:	CM15-0019355		
Date Assigned:	02/09/2015	Date of Injury:	11/08/2011
Decision Date:	03/31/2015	UR Denial Date:	01/30/2015
Priority:	Standard	Application Received:	02/03/2015

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 Jersey, Michigan, California
 Certification(s)/Specialty: Neurology, Neuromuscular 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:

The injured worker is a 54 year old male, who sustained an industrial injury on 11/08/2011. The diagnoses have included L5-S1 retrolisthesis grade I, foraminal protrusion at L3-L4, bilateral facet capsulitis at L4-L5, painful degenerative disc disease of the lumbar spine, radiculopathy and radiculitis, and bilateral sacroiliitis. Noted treatments to date have included physical therapy, brace, chiropractic treatment, epidural steroid injection, two radiofrequency ablation, facet injection, and medications. Diagnostics to date have included MRI of the lumbar spine on 08/27/2014 showed intraforaminal disc herniation on the left at L3-4 in the context of disc degeneration. In a progress note dated 01/22/2015, the injured worker presented with complaints of low back pain and bilateral leg pain with numbness and weakness. The treating physician reported the injured worker continues to have significant progressive back pain and bilateral leg pain with numbness. Utilization Review determination on 01/30/2015 non-certified the request for X-ray of Lumbar Spine and Sacroiliac Joint Injection. No guidelines were referenced in the Utilization Review report.

IMR ISSUES, DECISIONS AND RATIONALES

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

X-Ray of the lumbar spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304.

Decision rationale: According to MTUS guidelines, X-Ray of the lumbar spine is indicated in case of disc protrusion, post laminectomy syndrome, spinal stenosis and equina syndrome. There are no red flags pointing toward one of the above diagnosis or a serious spine pathology. The patient developed a back injury without any documentation of focal neurological examination. Therefore the request of X-Ray of the lumbar spine is not medically necessary.

Sacroiliac Joint Injection: 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 ODG) ODG Sacroiliac injections

Decision rationale: MTUS guidelines are silent regarding sacroiliac injections. According to ODG guidelines, sacroiliac injections are medically necessary if the patient fulfills the following criteria: 1. the history and physical examination should suggest the diagnosis; 2. Other pain generators should be excluded; 3. Documentation of failure of 4-6 weeks aggressive therapies; 4. Blocks are performed under fluoroscopy; 5. Documentation of 80% pain relief for a diagnostic block; 6. If steroids are injected during the initial injection, the duration of relief should be at least 6 weeks; 7. In the therapeutic phase, the interval between 2 block is at least 2 months; 8. The block is not performed at the same day as an epidural injection; 9. The therapeutic procedure should be repeated as needed with no more than 4 procedures per year. It is not clear from the patient file, that the patient fulfills the criteria of sacroiliac damage, that other pain generator have been excluded and failure of aggressive conservative therapies for at least 4 weeks. Therefore, the requested for Sacroiliac Joint Injection is not medically necessary.