

<b>Case Number:</b>	CM13-0028157		
<b>Date Assigned:</b>	03/03/2014	<b>Date of Injury:</b>	10/17/2003
<b>Decision Date:</b>	09/26/2014	<b>UR Denial Date:</b>	09/06/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/23/2013

### 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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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 72-year-old male who has submitted a claim for lumbar disc disease, lumbar radiculopathy, lumbar facet syndrome, and bilateral SI joint arthropathy, associated with an industrial injury date of October 17, 2003. Medical records from 2013 were reviewed. The patient complained of on and off back pain radiating to both shoulder blades. He received bilateral SI injection on July 29, 2013. Pain was decreased from 100% to 60% noted for the first 3-4 days. Physical examination showed an antalgic gait; tenderness over paravertebral muscles, facet joints, and SI joint; positive Faber's, SI thrust test, Kemp's and Yeoman's tests; and positive SLR seated and supine bilaterally. The diagnoses were lumbar disc disease, lumbar radiculopathy, lumbar facet syndrome, and bilateral SI joint arthropathy. Treatment to date has included oral and topical analgesics, physical therapy, chiropractic therapy, home exercise program, TENS, bilateral SI injection, and right sacroiliac radiofrequency rhizotomy of the joint under fluoroscopy (8/13/2007). Utilization review from September 6, 2013 denied the request for bilateral sacroiliac joint rhizotomy because pain response was not at least 70%. The request for hot/cold contrast system for home use was also denied. However, reason for denial was not available.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**BILATERAL SACROILIAC JOINT RHIZOTOMY:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 286-326. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip and Pelvis Chapter, Sacroiliac joint radiofrequency neurotomy.

**Decision rationale:** According to pages 286-326 of the ACOEM Guidelines referenced by CA MTUS states that radiofrequency lesioning of dorsal root ganglia for chronic sciatica is not recommended. ODG states that criteria for the use of sacroiliac blocks include: history and physical should suggest the diagnosis; failure of at least 4-6 weeks of aggressive conservative therapy including PT, home exercise and medication management; blocks are performed under fluoroscopy; if first block is not positive, a second diagnostic block is not performed; duration of pain relief should be at least 6 weeks with at least > 70% pain relief recorded; 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, previous bilateral SI injection was given on July 29, 2013. However, pain has only improved by 60% noted for the first 3-4 days. The guideline requires a pain response of at least > 70% for 6 weeks. Likewise, there was no objective evidence that conservative treatment has failed to manage pain. There was also no evidence that SI injection will be performed under fluoroscopy. The medical necessity for repeat injection was not established because guideline criteria were not met. There was no compelling rationale concerning the need for variance from the guideline. Therefore, the request for BILATERAL SACROILIAC JOINT RHIZOTOMY is not medically necessary.

**HOT/COLD CONTRAST SYSTEM FOR HOME USE:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** The dependent request of BILATERAL SACROILIAC JOINT RHIZOTOMY has been deemed not medically necessary; therefore, all the associated services, such as the request for post-procedure HOT/COLD CONTRAST SYSTEM FOR HOME USE, is likewise not medically necessary.