

Case Number:	CM14-0202112		
Date Assigned:	12/12/2014	Date of Injury:	04/20/2002
Decision Date:	11/24/2015	UR Denial Date:	11/06/2014
Priority:	Standard	Application Received:	12/02/2014

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: Preventive Medicine, Occupational 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:

This is a 54 year old male whose date of injury was 4-20-2002. Medical documentation on 10-1-14 indicated the injured worker was treated for lumbago, lumbar degenerative disc disease, lumbar radiculitis radiculopathy, ankle enthesopathy and sacralgia. He reported significantly increased pain and rated his pain a 6 on a 10-point scale (6 on 10-1-14). He was using 2 Norco every six hours for pain, which provided 50% pain relief. He had continued restricting pain in the lumbar spine and the right ankle. He had lumbar spine flexion to 30 degrees, extension to 15 degrees, and bilateral rotation to 20 degrees. He had tenderness to palpation over the bilateral erector spinae, bilateral lumbar facet joints. A seated root test was negative bilaterally. He had full motor power with manual testing of the bilateral legs and normal bilateral sensation in the lower extremities. He had a positive Fabers test and a positive compression test. He had pain over the bilateral sacroiliac joints. An MRI of the lumbar spine without contrast on 1-9-14 revealed interval decompression surgical changes at L3-4 with left hemilaminectomy and restoration of adequate central dimensions and no significant disc herniation or foraminal stenosis. A request for authorization for left sacroiliac joint injection under ultrasound guidance; right sacroiliac joint injection under ultrasound guidance; trigger point injections to the left lumbar region under ultrasound guidance; trigger point injections to the right lumbar region under ultrasound guidance, and MRI of the left foot-ankle with-without contrast was received on 10-28-14. On 11-06-14, the Utilization Review physician determined left sacroiliac joint injection under ultrasound guidance; right sacroiliac joint injection under ultrasound guidance; trigger point injections to the left lumbar region under ultrasound guidance; trigger point

injections to the right lumbar region under ultrasound guidance, and MRI of the left foot-ankle with-without contrast was not medically necessary based on CA MTUS ACOEM.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left sacro-iliac joint injection under ultrasound guidance: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods.

Decision rationale: Recommended as an option if failed at least 4-6 weeks of aggressive conservative therapy. Evidence of a recent comprehensive conservative treatment protocol trial and failure has not been submitted. Sacroiliac dysfunction is poorly defined and the diagnosis is often difficult to make due to the presence of other low back pathology (including spinal stenosis and facet arthropathy). The diagnosis is also difficult to make as pain symptoms may depend on the region of the SI joint that is involved. The MTUS does not support sacro-iliac joint injections for acute or chronic low back pain. Left sacro-iliac joint injection is not medically necessary.

Trigger point injection/s to the left lumbar region under ultrasound guidance, number of injection/s is not specified: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Trigger point injections.

Decision rationale: The MTUS states that trigger point injections are recommended only for myofascial pain syndrome with limited lasting value and not recommended for radicular pain. These injections may occasionally be necessary to maintain function in those with myofascial problems when myofascial trigger points are present on examination. Not recommended for typical back pain. Trigger point injections to the left lumbar region are not medically necessary.

Right sacro-iliac joint injection under ultrasound guidance: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods.

Decision rationale: Recommended as an option if failed at least 4-6 weeks of aggressive conservative therapy. Evidence of a recent comprehensive conservative treatment protocol trial and failure has not been submitted. Sacroiliac dysfunction is poorly defined and the diagnosis is

often difficult to make due to the presence of other low back pathology (including spinal stenosis and facet arthropathy). The diagnosis is also difficult to make as pain symptoms may depend on the region of the SI joint that is involved. The MTUS does not support sacro-iliac joint injections for acute or chronic low back pain. Right sacro-iliac joint injection is not medically necessary.

Trigger point injection/s to the right lumbar region under ultrasound guidance, number of injection/s not specified: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Trigger point injections.

Decision rationale: The MTUS states that trigger point injections are recommended only for myofascial pain syndrome with limited lasting value and not recommended for radicular pain. These injections may occasionally be necessary to maintain function in those with myofascial problems when myofascial trigger points are present on examination. Not recommended for typical back pain. Trigger point injections to the right lumbar region are not medically necessary.

MRI of the left foot/ankle with/without contrast: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, MRIs.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Ankle & Foot (Acute & Chronic), Magnetic resonance imaging (MRI).

Decision rationale: According to the Official Disability Guidelines, the primary criteria for ordering imaging studies are emergence of a red flag, physiologic evidence of tissue insult or neurovascular dysfunction, failure to progress in a strengthening program intended to avoid surgery, or clarification of the anatomy prior to an invasive procedure. The medical record is lacking documentation in any of the above criteria. MRI of the left foot/ankle is not medically necessary.