

Case Number:	CM13-0006597		
Date Assigned:	09/03/2013	Date of Injury:	07/14/2005
Decision Date:	02/25/2014	UR Denial Date:	07/29/2013
Priority:	Standard	Application Received:	08/05/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, 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 physician 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:

Diagnoses include thoracic or lumbosacral neuritis or radiculitis not otherwise specified; lumbar disc displacement without myelopathy; and lumbago. Treatment plan included right SI joint injection with fluoroscopic guidance. ODG note etiology for SI joint disorder includes degenerative joint disease, joint laxity, and trauma (such as a fall to the buttock). The main cause is SI joint disruption from significant pelvic trauma. 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 (anterior, posterior, and/or extra-articular ligaments). Although SI joint injection is recommended as an option for clearly defined diagnosis with positive specific tests for motion palpation and pain provocation for SI joint dysfunction, none have been demonstrated on medical reports submitted. It has also been questioned as to whether SI joint blocks are the "diagnostic gold standard" as the block is felt to show low sensitivity, and discordance has been noted between two consecutive blocks (questioning validity). (Schwarzer, 1995) There is also concern that pain relief from diagnostic blocks may be confounded by infiltration of extra-articular ligaments, adjacent muscles, or sheaths of the nerve roots themselves. Submitted reports have not met guidelines criteria including no clear specific clinical symptoms or findings consistent with sacroiliac dysfunction. The Right Sacroiliac (SI) Joint with Fluoroscopic Guidance, QTY 1.00 is not medically necessary and appropriate.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Sacroiliac (SI) Joint with Fluoroscopic Guidance, QTY 1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip Chapter pages 263-264

Decision rationale: Diagnoses include thoracic or lumbosacral neuritis or radiculitis not otherwise specified; lumbar disc displacement without myelopathy; and lumbago. Treatment plan included right SI joint injection with fluoroscopic guidance. ODG note etiology for SI joint disorder includes degenerative joint disease, joint laxity, and trauma (such as a fall to the buttock). The main cause is SI joint disruption from significant pelvic trauma. 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 (anterior, posterior, and/or extra-articular ligaments). Although SI joint injection is recommended as an option for clearly defined diagnosis with positive specific tests for motion palpation and pain provocation for SI joint dysfunction, none have been demonstrated on medical reports submitted. It has also been questioned as to whether SI joint blocks are the "diagnostic gold standard" as the block is felt to show low sensitivity, and discordance has been noted between two consecutive blocks (questioning validity). (Schwarzer, 1995) There is also concern that pain relief from diagnostic blocks may be confounded by infiltration of extra-articular ligaments, adjacent muscles, or sheaths of the nerve roots themselves. Submitted reports have not met guidelines criteria including no clear specific clinical symptoms or findings consistent with sacroiliac dysfunction. The Right Sacroiliac (SI) Joint with Fluoroscopic Guidance, QTY 1.00 is not medically necessary and appropriate.