Case Number:	CM13-0016351		
Date Assigned:	11/06/2013	**Date of Injury:**	01/08/2009
Decision Date:	01/31/2014	**UR Denial Date:**	08/15/2013
Priority:	Standard	**Application Received:**	08/26/2013

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 Emergency Medicine and is licensed to practice in New York and 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 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.

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 53-year-old male who suffered a right inguinal hernia from a work related injury on January 8, 2009. The hernia was repaired in October 2009. The patient continued to experience right groin pain. Treatment history was negative for physical therapy, acupuncture, traction, TENS unit, epidural steroids, biofeedback, chiropractor, nerve blocks, pain clinic, or psychologist. Medication for the patient's groin pain was Advil prn. The patient underwent 3 sets of nerve blocks. The first two gave him significant relief for one week. The third block was not successful in giving the patient relief from his pain. Request for authorization for right sacroiliac join injection was submitted on 8/8/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right sacroiliac joint injection under fluoroscopy and anesthesia: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM,Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip& Pelvis, 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& Pelvis, Sacroiliac Joint Blocks.

Decision rationale: Sacroiliac joint injections are recommended as an option if failed at least 4-6 weeks of aggressive conservative therapy as indicated below. 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 sacroiliac (SI) joint that is involved (anterior, posterior, and/or extra-articular ligaments). Pain may radiate into the buttock, groin and entire ipsilateral lower limb, although if pain is present above L5, it is not thought to be from the SI joint. Etiology 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. Specific tests for motion palpation and pain provocation have been described for SI joint dysfunction. These include Cranial Shear Test, Extension Test, Flamingo Test, Fortin Finger Test, Gaenslen's Test, Gillet's Test (One Legged-Stork Test), Patrick's Test (FABER), Pelvic Compression Test, Pelvic Distraction Test, Pelvic Rock Test, Resisted Abduction Test (REAB);,Sacroiliac Shear Test, Standing Flexion Test, Seated Flexion Test, and Thigh Thrust Test (POSH). Imaging studies are not helpful. It has been questioned as to whether SI joint blocks are the "diagnostic gold standard." The block is felt to show low sensitivity, and discordance has been noted between two consecutive blocks (questioning validity). 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. There is limited research suggesting therapeutic blocks offer long-term effect. There should be evidence of a trial of aggressive conservative treatment (at least six weeks of a comprehensive exercise program, local icing, mobilization/manipulation and anti-inflammatories) as well as evidence of a clinical picture that is suggestive of sacroiliac injury and/or disease prior to a first SI joint block. If helpful, the blocks may be repeated; however, the frequency of these injections should be limited with attention placed on the comprehensive exercise program. There is no history of trauma to the buttock or the pelvis. Documentation in the medical record does not support that criteria were met for the use of sacroiliac blocks. In this case the history is not suggestive of sacroiliac joint dysfunction. The patient had not failed an aggressive course of conservative therapy of at least 6 weeks duration. The patient had already had 3 sets of nerve blocks and attained relief for only 7-10 days after 2 of them. The use of sacroiliac blocks is not authorized in this case.