

<b>Case Number:</b>	CM14-0018489		
<b>Date Assigned:</b>	04/18/2014	<b>Date of Injury:</b>	02/16/1993
<b>Decision Date:</b>	06/30/2014	<b>UR Denial Date:</b>	01/27/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/13/2014

### 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. The expert reviewer is Board Certified in Physical Medicine & 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 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:

This 56 year-old patient sustained an injury on 2/16/1993 while employed by the [REDACTED]. Request(s) under consideration include LEFT SACROILIAC JOINT BLOCK. The patient is s/p three spinal fusions in 1993, 1995, and 2001. He underwent spinal cord stimulator revision on 9/20/12; scs exploration on 10/10/12 for injection, T4-5 laminectomy for removal of epidural spinal cord stimulator equipment under fluoroscopy on 8/1/13 due to fractured cervical leads. Conservative care has included medications (Oxycodone); however, most recent Urine Drug Screen on 9/18/13 was negative for Oxycodone with inconstancy; however, no change was instituted. Co-morbid medical history include hypertension, high cholesterol, abnormal heart rate, COPD, anxiety, depression, and most recent diagnosis of diabetes. Lumbar CT scan of 3/8/13 showed post-operative changes at L3-L5 bilateral laminectomy with screw fixation; L4-5 and L5-S1 disc implants, neural pacemaker through L2 and changes at right PSIS from bone graft harvest, multi-level osteophytes, and generalized degenerative changes of the lumbar spine. Report of 11/20/13 from the provider had no mention of left SI dysfunction. Report of 1/8/14 noted back and foot pain with burning. Low back pain radiates down left leg. Exam showed hypersensitive feet, tenderness over left SI joint, healed back midline incision with limited range; positive Faber's, cross step and Gillet's test with decreased sensation 1 inch proximal to the knees extending distally with burning and numbness. The patient's pain pump was refilled and he continues on oral OxyContin (40mg tid). Request(s) for LEFT SACROILIAC JOINT BLOCK was non-certified on 1/27/14 citing guidelines criteria and lack of medical necessity.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**LEFT SACROILIAC JOINT BLOCK:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

**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, SI Joint, Pages 263-264.

**Decision rationale:** ODG notes 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). 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 especially when previous SI injections have not been documented to have provided any functional improvement for this 1993 injury s/p multiple spinal surgery and spinal cord stimulator placement with complications of infection for this newly diagnosed diabetic patient. The left sacroiliac joint block is not medically necessary and appropriate.