

<b>Case Number:</b>	CM14-0139513		
<b>Date Assigned:</b>	09/05/2014	<b>Date of Injury:</b>	12/21/1998
<b>Decision Date:</b>	10/09/2014	<b>UR Denial Date:</b>	08/22/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/28/2014

### 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 and Rehabilitation & Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 injured worker is a 55-year-old female who reported an injury on 12/21/1998 due to slipping and falling on ice outside her building, landing on her low back and right sacral area. The diagnoses were chronic pain syndrome, degeneration of cervical intervertebral disc, degeneration of lumbar intervertebral disc, depressive disorder, back problem, low back pain, lumbosacral spondylosis without myelopathy, neck pain, thoracic radiculitis, brachial radiculitis, cervical spondylosis without myelopathy, and cervical radiculopathy. Past treatments were a radiofrequency ablation of the lumbar spine and medial branch blocks in 2011 that were not successful. Her surgical history was not reported. Medications were Norco, methadone, and Arthrotec. The physical examination on 08/08/2014 reported that the problem was stable. The injured worker's pain was in the lower back. It was reported that the pain radiated to the back, left foot, right foot, left thigh, and right thigh. The injured worker had recently had a sacroiliac joint injection with a 50% reduction in pain. The injured worker reported her pain at a 7/10 without the medications. The pain was rated a 3/10 with medications. The examination with the neurological revealed motor strength was normal. The musculoskeletal examination revealed right antalgic limp due to right hip and low back pain; tender to palpation on both sacroiliac joints with provocative testing. The treatment plan was for bilateral sacroiliac joint medial and lateral branch blocks and a radiofrequency ablation of the sacroiliac joint. The rationale and Request for Authorization were not submitted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **Bilateral SI Joint Medial and Lateral Branch Blocks S1, S2: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-301. Decision based on Non-MTUS Citation Official Disability Guidelines: Hip & Pelvis, criteria for use of sacroiliac 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 and Pelvis, Sacroiliac Joint Blocks

**Decision rationale:** The Official Disability Guidelines state sacroiliac joint blocks are recommended as an option if failed at least 4 to 6 weeks of aggressive conservative therapy as indicated. 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). Pain may radiate into the buttocks, groin, and entire ipsilateral lower limb, although if pain is present above L5, it is not thought to be from the SI joint. Specific testing for motion palpation and pain provocation had been described for SI joint dysfunction such as cranial shear tests, extension tests, flamingo tests, Fortin finger tests, Gaenslen's test, Gillet's test, Patrick's test (Faber), and pelvic compression tests. 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 2 consecutive blocks (questioning validity). Criteria for the use of sacroiliac blocks are: the history and physical should suggest the diagnosis (with documentation of at least 3 positive examination findings as listed above); diagnostic evaluation must first address any other possible pain generators; the patient has had and failed at least 4 to 6 weeks of aggressive conservative therapy including PT, home exercise, and medication management; blocks are performed under fluoroscopy; a positive diagnostic response is recorded as 80% for the duration of the local anesthetic, and if the first block is not positive, a second diagnostic block is not performed; if steroids are injected during the initial injection, the duration of pain relief should be at least 6 weeks with at least a greater than 70% pain relief recorded for this period; in the treatment or therapeutic phase (after the stabilization is completed), the suggested frequency for repeat blocks is 2 months or longer between each injection, provided that at least greater than 70% pain relief is obtained for 6 weeks; the block is not to be performed on the same day as a lumbar epidural steroid injection, transforaminal epidural steroid injection, facet joint injection, or medial branch block; and in the treatment or therapeutic phase, the interventional procedures should be repeated only as necessary judging by the medical necessity criteria, and these should be limited to a maximum of 4 times for local anesthetic and steroid blocks over a period of 1 year. It was not reported that the injured worker had 4 to 6 weeks of aggressive conservative therapy including PT or home exercise. The injured worker had a previous sacroiliac joint injection on 07/07/2014 and it was reported on her physical examination on 08/08/2014. The clinical documentation submitted for review does not provide evidence to support the request for bilateral SI joint injections. Therefore, the request is not medically necessary.

## **Bilateral SI Joint Medial and Lateral Branch Blocks S3, S4: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-301. Decision based on Non-MTUS Citation Official Disability Guidelines: Hip & Pelvis, criteria for use of sacroiliac 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 and Pelvis, Sacroiliac Joint Blocks

**Decision rationale:** The Official Disability Guidelines state sacroiliac joint blocks are recommended as an option if failed at least 4 to 6 weeks of aggressive conservative therapy as indicated. 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). Pain may radiate into the buttocks, groin, and entire ipsilateral lower limb, although if pain is present above L5, it is not thought to be from the SI joint. Specific testing for motion palpation and pain provocation had been described for SI joint dysfunction such as cranial shear tests, extension tests, flamingo tests, Fortin finger tests, Gaenslen's test, Gillet's test, Patrick's test (Faber), and pelvic compression tests. 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 2 consecutive blocks (questioning validity). Criteria for the use of sacroiliac blocks are: the history and physical should suggest the diagnosis (with documentation of at least 3 positive examination findings as listed above); diagnostic evaluation must first address any other possible pain generators; the patient has had and failed at least 4 to 6 weeks of aggressive conservative therapy including PT, home exercise, and medication management; blocks are performed under fluoroscopy; a positive diagnostic response is recorded as 80% for the duration of the local anesthetic, and if the first block is not positive, a second diagnostic block is not performed; if steroids are injected during the initial injection, the duration of pain relief should be at least 6 weeks with at least a greater than 70% pain relief recorded for this period; in the treatment or therapeutic phase (after the stabilization is completed), the suggested frequency for repeat blocks is 2 months or longer between each injection, provided that at least greater than 70% pain relief is obtained for 6 weeks; the block is not to be performed on the same day as a lumbar epidural steroid injection, transforaminal epidural steroid injection, facet joint injection, or medial branch block; and in the treatment or therapeutic phase, the interventional procedures should be repeated only as necessary judging by the medical necessity criteria, and these should be limited to a maximum of 4 times for local anesthetic and steroid blocks over a period of 1 year. It was not reported that the injured worker had 4 to 6 weeks of aggressive conservative therapy including PT or home exercise. The injured worker had a previous sacroiliac joint injection on 07/07/2014 and it was reported on her physical examination on 08/08/2014. The clinical documentation submitted for review does not provide evidence to support the request for bilateral SI joint injections. Therefore, the request is not medically necessary.

**RFA SI Joint:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Hip & Pelvis, Sacroiliac joint radiofrequency neurotomy

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip and Pelvis, Sacroiliac Joint Radiofrequency Neuroitomy

**Decision rationale:** The Official Disability Guidelines state sacroiliac joint radiofrequency neurotomy is not recommended. multiple techniques are currently described: a bipolar system using radiofrequency probes; sensory stimulation guided sacral lateral branch radiofrequency neurotomy; lateral branch blocks (nerve blocks at the L4-5 primary dorsal rami and S1-S3 lateral branches); and pulsed radiofrequency denervation of the medial branch of L4, the posterior rami of L5, and lateral branches of S1 and S2. This latter study applied the technique to patients with confirmatory block diagnosis of SI joint pain that did not have long term relief from these diagnostic injections. There was no explanation of why pulse radiofrequency denervation was successful when other conservative treatment was not. The use of all these techniques has been questioned, in part, due to the fact that the innervation of the SI joint remains unclear. There is also controversy over the correct technique for radiofrequency denervation. A recent review of this intervention in a journal sponsored by the American Society of Interventional Pain Physicians found that the evidence was limited for this procedure. The medical guidelines do not support the use of a sacroiliac radiofrequency neurotomy. Therefore, the request is not medically necessary.