

<b>Case Number:</b>	CM14-0150866		
<b>Date Assigned:</b>	10/20/2014	<b>Date of Injury:</b>	10/12/2011
<b>Decision Date:</b>	11/20/2014	<b>UR Denial Date:</b>	08/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/16/2014

### 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 10/12/11 from stepping on a stone, twisting his ankle and breaking his fall with the left hand while employed by [REDACTED]. Request(s) under consideration include Right sacroiliac joint injection under fluoroscopy guidance and Right transforaminal lumbar epidural steroid injection at level L5-S1 under fluoroscopy guidance distribution of radiculitis radiculopathy of lower extremities. Diagnoses include lumbar intervertebral disc displacement without displacement/ lumbago/ thoracic lumbosacral neuritis/ radiculitis; Pelvic joint and thigh pain. MRI of the lumbar spine dated 12/27/11 showed multilevel disc protrusions. Report of 2/4/14 from a pain management provider noted the patient was authorized for his third lumbar epidural steroid injection at L5-S1 with 75% relief from his first two injections. Pain persists in the low back radiating down right leg into right foot with numbness in great toe. Exam showed diffuse motor weakness of 4/5 throughout right lower extremity with diffuse decreased sensation at L4, L5, and S1 dermatomes. Treatment included proceeding with scheduled LESI. The patient continued on Norco and Zanaflex. Report of 7/3/14 from the provider noted ongoing chronic low back pain with associated burning, tingling and numbness radiating to right buttock and down lateral right thigh. Exam showed limited lumbar range with spasm; normal gait; palpating right SI joint reproduced sharp shooting pain down posterior lateral right thigh with positive SI thrust test, Gaenslen's, Patrick's, and Faber's tests. Diagnoses included lumbar muscular ligamentous injury/ paraspinal spasm/ disc herniations/ radiculitis; and right sacroiliitis. The request(s) for Right sacroiliac joint injection under fluoroscopy guidance and Right transforaminal lumbar epidural steroid injection at level L5-S1 under fluoroscopy guidance distribution of radiculitis radiculopathy of lower extremities were non-certified on 8/15/14 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:

### **Right sacroiliac joint injection under fluoroscopy guidance: 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 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, SI Joint, pages 263-264

**Decision rationale:** 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 distinguishing defined etiology in a patient with concurrent radicular symptoms. 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 injections have not been documented to have provided any functional improvement for this 2011 injury. The Right sacroiliac joint injection under fluoroscopy guidance is not medically necessary and appropriate.

### **Right transforaminal lumbar epidural steroid injection at level L5-S1 under fluoroscopy guidance distribution of radiculitis radiculopathy of lower extremities: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections, (ESIs) Page(s): 46.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

**Decision rationale:** The patient had completed a series of three LESI in early 2014. MTUS Chronic Pain Medical Treatment Guidelines recommend ESI as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy); however, radiculopathy must be documented on physical examination and corroborated by imaging studies and/or Electrodiagnostic testing, not provided here with diffuse findings. Submitted reports have not demonstrated any correlating neurological deficits or

remarkable diagnostics to support the epidural injections. Criteria for repeating the epidurals have not been met or established. There is also no documented failed conservative trial of physical therapy, medications, activity modification, or other treatment modalities to support for the repeat epidural injection. Lumbar epidural injections may be an option for delaying surgical intervention; however, there is no surgery planned or identified pathological lesion noted. Although the provider reported improvement post previous injections, the patient continues with unchanged symptom severity, unchanged clinical findings without specific decreased in medication profile, treatment utilization or functional improvement described in terms of increased rehabilitation status or activities of daily living for this 2011 injury. Criteria for repeating the epidurals have not been met or established. The Right transforaminal lumbar epidural steroid injection at level L5-S1 under fluoroscopy guidance distribution of radiculitis radiculopathy of lower extremities is not medically necessary and appropriate.