

<b>Case Number:</b>	CM14-0049640		
<b>Date Assigned:</b>	07/07/2014	<b>Date of Injury:</b>	07/03/2011
<b>Decision Date:</b>	08/22/2014	<b>UR Denial Date:</b>	04/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/17/2014

### 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:

According to the records made available for review, this is a 53-year-old female with a 7/3/11 date of injury, and status post anterior posterior fusion L5-S1 8/28/12, and status post revision laminotomy, decompression at L5-S1 and removal of posterior hardware 9/26/12. At the time (3/24/14) of request for authorization for bilateral sacroiliac joint injection with fluoroscopy. There is documentation of subjective low back pain, right and left leg pain, some residual right lower extremity weakness, and worsening sacroiliac joint pain bilaterally. The objective findings included antalgic gait, tenderness to palpation over sacroiliac (SI) joints bilaterally, lumbar range of motion limited secondary to pain, 5/5 motor strength proximally and distally bilaterally, normal sensation to light touch bilateral lower extremities, deep tendon reflexes 2+ and equal bilaterally knees and ankles, straight leg raising at 90 degrees causes low back pain and pain radiating into right leg, and FABER positive bilaterally. Her current diagnoses are sacroiliitis with sacroiliac joint inflammation, status post L5-S1 fusion with significant improvement, neuropathic right leg pain, spondylolisthesis at L5-S1 stabilized after surgery, and status post removal of posterior hardware with significant improvement postoperative. Treatment to date is right sacroiliac joint injection 10/1/13 with significant and substantial pain relief temporarily, anti-inflammatory medications, physical therapy, chiropractic treatments, home exercise program, and activity modifications. There is no documentation of two additional positive (left) exam findings, diagnostic evaluation first addressing any other possible pain generators; and at least greater than >70% pain relief obtained for 6 weeks with prior right sacroiliac joint injection.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **Bilateral sacroiliac joint injection with fluoroscopy: 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 and Pelvis chapter, Criteria for the use of sacroiliac blocks.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Hip & Pelvis Chapter, SI Joint Injection.

**Decision rationale:** MTUS reference to ACOEM Guidelines identifies that invasive techniques are of questionable merit. Despite the fact that proof is still lacking, many pain physicians believe that diagnostic and/or therapeutic injections may have a benefit in patients presenting in the transitional phase between acute and chronic pain. Official Disability Guidelines (ODG) identifies documentation of at least 3 positive exam findings [such as: 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/or Thigh Thrust Test (POSH)]; diagnostic evaluation first addressing any other possible pain generators; failure of at least 4-6 weeks of aggressive conservative therapy (including physical therapy, home exercise and medication management); block to be performed under fluoroscopy; and block not to be performed on the same day as a lumbar epidural steroid injection (ESI), transforaminal ESI, facet joint injection or medial branch block, as criteria necessary to support the medical necessity of sacroiliac (SI) joint injection. The ODG identifies documentation of at least >70% pain relief obtained for 6 weeks, that 2 months or longer have elapsed between each injection, and that the injection is not to be performed on the same day as a lumbar epidural steroid injection (ESI), transforaminal ESI, facet joint injection or medial branch block, as criteria necessary to support the medical necessity of repeat SI joint injection. Within the medical information available for review, there is documentation of diagnoses of sacroiliitis with sacroiliac joint inflammation, status post L5-S1 fusion with significant improvement, neuropathic right leg pain, spondylolisthesis at L5-S1 stabilized after surgery, and status post removal of posterior hardware with significant improvement postoperative. In addition, there is documentation of a previous right sacroiliac joint injection on 10/1/13; that 2 months or longer have elapsed between each injection; block to be performed under fluoroscopy; and block not to be performed on the same day as a lumbar epidural steroid injection (ESI), transforaminal ESI, facet joint injection or medial branch block. Furthermore, there is documentation failure of at least 4-6 weeks of aggressive conservative therapy (PT, home exercise and medication management) and 1 positive (left) exam finding (Patrick's Test (FABER)). However, there is no documentation of 2 additional positive (left) exam findings [Cranial Shear Test; Extension Test; Flamingo Test; Fortin Finger Test; Gaenslen's Test; Gillet's Test (One Legged-Stork Test); Pelvic Compression Test; Pelvic Distraction Test; Pelvic Rock Test; Resisted Abduction Test (REAB); Sacroiliac Shear Test; Standing Flexion Test; Seated Flexion Test; and/or Thigh Thrust Test (POSH)]. In addition, there is no documentation of diagnostic evaluation first addressing any other possible pain generators. Furthermore, despite documentation of significant and substantial pain relief temporarily with previous right SI joint

injection, there is no documentation of at least >70% pain relief obtained for 6 weeks. Therefore, based on guidelines and a review of the evidence, the request for Bilateral sacroiliac joint injection with fluoroscopy is not medically necessary.