

<b>Case Number:</b>	CM14-0073429		
<b>Date Assigned:</b>	07/16/2014	<b>Date of Injury:</b>	12/31/2009
<b>Decision Date:</b>	09/08/2014	<b>UR Denial Date:</b>	05/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/21/2014

### 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, has a subspecialty in Interventional Spine 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:

The patient is a 52 year-old female with a date of injury of 12/31/2009. The listed diagnoses per [REDACTED] dated 05/01/2014 are: 1. S/P positive fluoroscopically-guided diagnostic bilateral sacroiliac joint injection. 2. Bilateral sacroiliac joint pain, left worse than the right. 3. Lumbar facet joint pain. 4. Lumbar facet joint arthropathy. 5. Lumbar sprain/strain. 6. Left knee internal derangement. 7. Left knee surgery. According to this report, the patient complains of bilateral low back pain radiating to the bilateral buttocks. The patient is status post positive fluoroscopically-guided diagnostic bilateral sacroiliac joint injection with 80% improvement and increased range of motion 30 minutes after the injection that lasted greater than 2 hours. The physical examination shows tenderness upon palpation of the bilateral sacroiliac joint sulcus. Muscle growth is symmetric in all limbs. Peripheral pulses are 2+ bilaterally with normal capillary refill. Left knee ranges of motion are restricted by pain in all directions. Lumbar ranges of motion were restricted by pain in all directions. Heel, toe, and tandem walking were within normal limits. The utilization review denied the request on 05/16/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Fluoroscopically Guided Therapeutic Bilateral Sacroiliac Joint Injection:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter - Lumbar & Thoracic (Acute & Chronic): Sacroiliac Joint Injections (SJI); Hip and Pelvis (Acute & Chronic) Chapter: 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) SI Joint Syndrome ODG guideline have the following regarding SI joint injections in their Pelvic/Hip chapter: 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 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. Innervation: The anterior portion is thought to be innervated by the posterior rami of the L1-S2 roots and the posterior portion by the posterior rami of L4-S3. although the actual innervation remains unclear. Anterior innervation may also be supplied by the obturator nerve, superior gluteal nerve and/or lumbosacral trunk. (Vallejo, 2006) Other research supports innervation by the S1 and S2 sacral dorsal rami. 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. Diagnosis: Specific tests for motion palpation and pain provocation have been described for SI joint dysfunction: 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; 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). (Schwarzer, 1995) 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. Sacral lateral branch injections have demonstrated a lack of diagnostic power and area not endorsed for this purpose. (Yin, 2003) Treatment: 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. (Forst, 2006) (Berthelot, 2006) (van der Wurff, 2006) (Laslett, 2005) (Zelle, 2005) (McKenzie-Brown 2005) (Pekkafahli, 2003) (Manchikanti, 2003) (Slipman, 2001) (Nelemans-Cochrane, 2000) See also Intra-articular steroid hip injection; & Sacroiliac joint radiofrequency neurotomy. Recent research: A systematic review commissioned by the American Pain Society (APS) and conducted at the Oregon Evidence-Based Practice Center states that there is insufficient evidence to evaluate validity or utility of diagnostic sacroiliac joint block, and that there is insufficient evidence to adequately evaluate benefits of sacroiliac joint steroid injection. (Chou, 2009) The latest AHRQ Comparative Effectiveness Report, covering Pain Management Interventions for Hip Fracture, concluded that nerve blockade was effective for relief of acute pain; however, most studies were limited to either assessing acute pain or use of additional analgesia and did not report on how nerve blockades may affect rehabilitation.

**Decision rationale:** This patient presents with low back pain radiating to the bilateral buttocks.

The treating physician is requesting a fluoroscopically-guided therapeutic bilateral Sacroiliac Joint Injection. The MTUS and ACOEM Guidelines do not address sacroiliac joint injections, however, ODG Guidelines recommend SI joint injections as an option if the patient has 3 positive exam findings for SI joint syndrome; diagnostic evaluation have addressed other possible pain generators; at least 4 to 6 weeks of aggressive conservative therapy including physical therapy, home exercises, and medication management. The progress report dated 05/01/2014 notes that the patient underwent a positive fluoroscopically-guided diagnostic bilateral sacroiliac joint injection on 04/17/2014 with 80% improvement and increased range of motion 30 minutes after the injection that lasted greater than 2 hours. The ODG further states that for repeat blocks, previous injections should provide at least greater than 70% pain relief for 6 weeks and a maximum of 4 injections per year. The guidelines do not discuss diagnostic injections for SI joints. Diagnostic injections are typically used for nerve root or facet joint pains to determine the level of pain. In this case, repeat injections require minimum of 6 weeks of relief following the SI joint injection along with functional improvement. This was not observed in this patient, therefore, the request for a Fluoroscopically-Guided Therapeutic Sacroiliac Joint Injection is not medically necessary.

**Follow-up Visit after injection:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints  
Page(s): 341.

**Decision rationale:** This patient presents with low back pain radiating to the bilateral buttocks. The treating physician is requesting a follow-up visit after injection. The ACOEM Guidelines, page 341, supports orthopedic follow-up evaluations every 3 to 5 days, whether in person or telephone. In this case, the bilateral SI joint injection was not medically necessary and the follow-up visit is not medically necessary as well.