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| <b>Case Number:</b>   | CM14-0074469 |                              |            |
| <b>Date Assigned:</b> | 07/16/2014   | <b>Date of Injury:</b>       | 10/22/2013 |
| <b>Decision Date:</b> | 09/17/2014   | <b>UR Denial Date:</b>       | 05/06/2014 |
| <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 & 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 48 year-old patient sustained an injury on 10/22/13 from moving a box of products while employed by [REDACTED]. Request(s) under consideration include SI Joint Injection. Report of 11/7/13 from a provider noted lower back and right sciatic symptoms rated at 8/10 unchanged. Exam showed muscle spasm, decreased lumbar range in all planes; negative SLR; 2+ DTRs symmetrical; tenderness at right paraspinal musculature; intact sensation in both legs, intact motor strength with normal gait and toe/heel walking. Diagnoses included lumbosacral sprain/strain; muscle spasm; right sciatica. Medications list Ibuprofen, Tramadol/Acet. The patient was on modified duties. Report from pain management provider dated 1/30/14 noted patient with ongoing low back pain rated at 5-7/10 radiating to bilateral groin. MRI of lumbar spine dated 12/3/13 showed small multilevel disc bulge of lumbar spine at L1-2, L2-3, L4-5, and L5-S1; minimal foraminal encroachment on right side of L5-S1; mild facet arthropathy at L3-4 and L4-5; no evidence of canal or NF stenosis. No exam was documented. Treatment plan recommended LESI. Per follow-up report from the pain management provider, the patient continues with right lower back pain. The patient underwent recent right L5 transforaminal epidural steroid injection on 4/2/14 with report 50% relief mostly in the thigh and leg. Exam showed tenderness at right greater trochanter and right SI joint; positive facet loading on right. Treatment included multiple injections. The request(s) for SI Joint Injection was non-certified on 5/6/14 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:

**SI Joint Injection:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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 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 lifting injury. The SI Joint Injection is not medically necessary and appropriate.