

<b>Case Number:</b>	CM14-0185015		
<b>Date Assigned:</b>	11/12/2014	<b>Date of Injury:</b>	11/05/2013
<b>Decision Date:</b>	01/02/2015	<b>UR Denial Date:</b>	10/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/06/2014

### 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 61 year old female with an injury date of 11/05/13. Based on the 10/17/14 progress report provided by treating physician, the patient complains of lower backache, status post transforaminal lumbar injection (left L4) 08/02/14. Physical examination to the lumbar spine revealed tenderness to palpation to L4 and L5, and range of motion was limited, especially on flexion 10 degrees. Lumbar facet loading positive bilaterally. Tenderness noted over the sacroiliac spine. Gaellen's and FABER test positive. Medications include Naproxen and Neurontin. Per treating physician's report dated 07/21/14, patient's pain is rated 2-4/10, and uses ice and heat to help her. Patient is working modified duty. Request for Authorization form dated 10/20/14 states "sacroiliac joint injection, left side" for the diagnosis of "sacroiliitis." EMG Study, per progress report dated 07/21/14 shows: delayed left tibial H reflex as may be seen in S1 radiculopathy; no evidence of active lumbar radiculopathy; no evidence of generalized peripheral neuropathy, peripheral nerve entrapment, plexopathy, myopathy or anterior horn cell disease in the above study. Diagnosis 07/21/14: degenerative disc disease of the lumbar spine; S1 radiculopathy. Diagnosis 10/17/14: sacroiliitis; lumbar disc herniation without myelopathy; lumbar disc degeneration; lumbar spondylosis without myelopathy/facet artho; lumbar/thoracic rad; low back pain syndrome. The utilization review determination being challenged is dated 10/23/14. Treatment reports were provided from 04/25/14 - 10/17/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left SI joint injection:** 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), Treatment Index, 18th Edition (web), 2013, Treatment in Workers Compensation, Hip-Sacroiliac Injections

**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 Chapter, Sacroiliac Joint blocks

**Decision rationale:** The patient presents with lower backache rated 2-4/10. The request is for Left SI Joint Injection. Patient is status post transforaminal lumbar injection (left L4) 08/02/14. Patient's diagnosis dated 10/17/14 included sacroiliitis and lumbar disc herniation without myelopathy. EMG study, per progress report dated 07/21/14 revealed "delayed left tibial H reflex as may be seen in S1 radiculopathy." Medications include Naproxen and Neurontin. ODG-TWC, Hip and Pelvis Chapter states: "Sacroiliac Joint blocks: Recommended as an option if failed at least 4-6 weeks of aggressive conservative therapy as indicated below. Criteria for the use of sacroiliac blocks: 1. The history and physical should suggest the diagnosis (with documentation of at least 3 positive exam findings as listed above). 2. Diagnostic evaluation must first address any other possible pain generators. 3. The patient has had and failed at least 4-6 weeks of aggressive conservative therapy including PT, home exercise and medication management." ODG further states that, "The history and physical should suggest the diagnosis (with documentation of at least 3 positive exam findings as listed..." "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). Request for Authorization form dated 10/20/14 states "sacroiliac joint injection, left side" for the diagnosis of "sacroiliitis." Per treating physician's report dated 07/21/14, uses ice and heat to help her, as well as medications. No physical therapy was noted. Physical examination on 10/17/14 revealed tenderness noted over the sacroiliac spine. Gaenslen's and FABER tests positive. Treating physician documents 2 positive exam findings. Review of medical records do not show that aggressive conservative therapy has been exhausted. Furthermore, patient's pain rating is 2-4/10. The request does not meet guideline indications. Recommendation is that the request is not medically necessary.