

<b>Case Number:</b>	CM15-0185517		
<b>Date Assigned:</b>	09/25/2015	<b>Date of Injury:</b>	12/08/1999
<b>Decision Date:</b>	11/09/2015	<b>UR Denial Date:</b>	08/26/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/21/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 injured worker is a(n) 61 year old female, who sustained an industrial injury on 12-8-99. The injured worker was diagnosed as having sacroiliitis, unspecified thoracic-lumbar neuritis and post lumbar laminectomy syndrome. The physical exam (2-17-15 through 6-17-15) revealed 2-5 out of 10 pain at best and a 10 out of 10 at worst, "decreased" lumbar range of motion and a positive straight leg raise test bilaterally. Treatment to date has included an H-wave unit, an L3-L4 epidural injection on 7-15-15 with 50% relief, Trazodone, Lyrica, Cymbalta, Dilaudid, MS Contin and Soma. As of the PR2 dated 8-11-15, the injured worker reports low back pain. She rates her pain 4 out of 10 at best and 8 out of 10 at worst. Objective findings include tenderness in the bilateral sacroiliac joints, a positive Faber's sign bilaterally and "decreased" lumbar range of motion. The treating physician requested a bilateral sacroiliac joint injection with fluoroscopic guidance. On 8-19-15 the treating physician requested a Utilization Review for a bilateral sacroiliac joint injection with fluoroscopic guidance. The Utilization Review dated 8-26-15, non-certified the request for a bilateral sacroiliac joint injection with fluoroscopic guidance.

### 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 fluoroscopic guidance:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Low back; Chapter Sacroiliac joint injections (SJI).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter under SI joint injections.

**Decision rationale:** Based on the 8/11/15 progress report provided by the treating physician, this patient presents with constant, sharp, throbbing, burning and radiating low back pain with electricity and pins/needles sensation rated 4 at least and 9 at worst. The treater has asked for bilateral sacroiliac joint injection with fluoroscopic guidance on 8/11/15. The patient's diagnosis per request for authorization dated 8/19/15 is disorders sacrum. The patient states that medication improves her condition per 8/11/15 report. The patient is using an H-wave unit which is helpful per 8/11/15 report. The patient is s/p lumbar epidural steroid injection from 7/15/15 which gave 50% relief per 8/11/15 report. The patient states that her back pain is increased by sitting/standing/walking per 6/17/15 report. The patient had a lumbar MRI sometime between 2/17/15 and 4/22/15 which showed stenosis at L3-4 per 4/22/15 report. The patient is deferring surgical intervention as she does not want to be cut on anymore per 4/27/15 report. The patient's work status is permanent and stationary per 6/17/15 report. ODG-TWC, Low Back Chapter under SI joint injections Section, not recommend therapeutic sacroiliac intra-articular or periarticular injections for non-inflammatory sacroiliac pathology (based on insufficient evidence for support). Recommend on a case-by-case basis injections for inflammatory spondyloarthropathy (sacroiliitis). This is a condition that is generally considered rheumatologic in origin (classified as ankylosing spondylitis, psoriatic arthritis, reactive arthritis, arthritis associated with inflammatory bowel disease, and undifferentiated spondyloarthropathy). Instead of injections for non-inflammatory sacroiliac pathology, conservative treatment is recommended. Review of the reports did not show any evidence of prior sacroiliac joint injections. The treater is requesting bilateral sacroiliac joint injections to help with ongoing SI joint dysfunction. There is tenderness and antalgic gait. The patient continues with pain in the low back and is diagnosed with sacroiliitis, thoracic/lumbosacral neuritis/radiculitis, and postlaminectomy syndrome lumbar region. Physical exam on 8/11/15 showed bilateral tenderness to palpation of sacroiliac joint, positive bilateral Faber's test, and positive bilateral Gaenslen's test. In this case, the patient has failed conservative treatment including ice, H-wave, medications, epidural steroid injections, and has positive exam findings showing bilateral sacroiliac joint dysfunction. However, review of reports do not show evidence of inflammatory SI joint problems as documented by radiology, X-rays, bone scan or MRI/CT scans. ODG guidelines do not recommend SI Joint Injections for non-inflammatory sacroiliac pathology. This request does not meet guidelines indication for bilateral SI Joint Injection. Therefore, the request is not medically necessary.