

<b>Case Number:</b>	CM15-0193079		
<b>Date Assigned:</b>	10/07/2015	<b>Date of Injury:</b>	03/01/2011
<b>Decision Date:</b>	11/18/2015	<b>UR Denial Date:</b>	09/17/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/01/2015

### 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: New York, Tennessee  
Certification(s)/Specialty: Emergency Medicine

### 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 40 year old, male who sustained a work related injury on 3-1-11. A review of the medical records shows he is being treated for lower back pain. Treatments have included medications, psychotherapy, and home exercises. Current medications include Norco, Etodolac and Norflex. In the progress notes, the injured worker reports persistent lower back pain. He describes the pain as deep and aching associated with intermittent spasms. He rates his pain level a 6 out of 10. This pain level has not changed in the last few visits. He notes when he increases his activity level, his pain "increases." He states current medications "decrease" his pain level and help with "increased" activity level. In the objective findings dated 8-7-15, he has tenderness and spasms noted in the lumbar paraspinal muscle. He has stiffness with lumbar range of motion. He has tenderness to bilateral facet joints. Sensory to touch is normal in legs. He has normal strength in legs. The provider states the MRI of the lumbar spine dated 8-1-11 reveals "broad based disc bulge at L5-S1 causing narrowing of the left neural foramen. At S1 there is no foramen narrowing. Minimal facet arthropathy at L5-S1." He is not working. The treatment plan includes requests for medication refills. In the Utilization Review dated 9-17-15, the requested treatment of left sacroiliac injection is not medically necessary.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**LT Sacroiliac 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: Hip & Pelvis (Acute & Chronic) - Sacroiliac injections, therapeutic.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip& Pelvis, sacroiliac joint blocks.

**Decision rationale:** Sacroiliac joints are 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. 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. Specific tests for motion palpation and pain provocation have been described for SI joint dysfunction. These include 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 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). 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. 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. Criteria for the use of sacroiliac blocks: 1. 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. 4. Blocks are performed under fluoroscopy. 5. A positive diagnostic response is recorded as 80% for the duration of the local anesthetic. If the first block is not positive, a second diagnostic block is not performed. 6. If steroids are injected during the initial injection, the duration of pain relief should be at least 6 weeks with at least > 70% pain relief recorded for this period. 7. In the treatment or therapeutic phase (after the stabilization is completed), the suggested frequency for repeat blocks is 2 months or longer between each injection, provided that at least >70% pain relief is obtained for 6 weeks. 8. The block 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. 9. In the treatment or therapeutic phase, the interventional procedures should be repeated only as necessary judging by the medical necessity criteria, and these should be limited to a maximum of 4 times for local anesthetic and steroid blocks over a period of 1 year. In this case the documentation in the medical record does not support the diagnosis of sacroiliac dysfunction. There is no documentation that at least three of the specific tests for sacroiliac dysfunction are positive.

There is no documentation that the patient that the patient has failed at four to six weeks of conservative therapy. Criteria for sacroiliac joint dysfunction have not been met. The request should not be authorized. Therefore, the request is not medically necessary.