

Case Number:	CM15-0211551		
Date Assigned:	10/30/2015	Date of Injury:	11/14/2012
Decision Date:	12/18/2015	UR Denial Date:	10/13/2015
Priority:	Standard	Application Received:	10/27/2015

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, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, Pain Management

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 female with an industrial injury dated 11-14-2012. A review of the medical records indicates that the injured worker is undergoing treatment for right sacroiliac (SI) sprain, right piriformis muscle spasm, and depression and muscle ligament dis nos. According to the progress note dated 09-30-2015, the injured worker reported back pain with occasional radiation of pain to the right leg. Documentation (09-30-2015) noted that the injured worker had 75% reduction in her pain with the right sacroiliac (SI) joint injection and piriformis injection. Pain level was 4-6 out of 10 on a visual analog scale (VAS). Aggravating factors is increased activity and alleviating factors are changing positions. The injured worker reported some difficulties with activities of daily living. Objective findings (09-30-2015) revealed limited abduction of right lower extremity due to pain and tightness of the hip abductors, trigger point of right piriformis, decreased lumbar spine range of motion due to pain, mild tenderness of the lumbosacral spine and paraspinals with mild paralumbar muscle tightness. Physical exam also revealed tenderness of the sacroiliac (SI) joint and gluteal area reproducing pain in the low back on the right. The treating physician noted that the Electromyography (EMG) and nerve conduction studies (NCS) revealed no evidence of neuropathic process and Magnetic Resonance Imaging (MRI) of lumbosacral spine revealed desiccated L5-S1 with attenuation of the central ventral subarachnoid space without impingement. Treatment has included diagnostic studies, medications, physical therapy, acupuncture therapy, sacroiliac and piriformis injections, and periodic follow up visits. The utilization review dated 10-13-2015,

non-certified the request for outpatient ultrasound guided right sacroiliac joint-ligaments cortisone injection and right piriformis injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient ultrasound guided right sacroiliac joint/ligaments cortisone injection and right piriformis 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, 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 & Pelvis, Piriformis Injections, sacroiliac joint blocks.

Decision rationale: The MTUS is silent on the use of sacroiliac joint injections. Per ODG TWC with regard to sacroiliac joint injections: "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.
4. Blocks are performed under fluoroscopy. (Hansen, 2003)
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. The documentation submitted for review noted positive Patrick's, FABERs, and Gaenslen's test on the right. It was noted that the injured worker has previously undergone physical therapy, acupuncture, SI and piriformis injections, ESI, and medication management. Sacroiliac joint injection may be indicated. The MTUS guidelines are silent on piriformis block. Per the ODG guidelines "Recommended for piriformis syndrome after a one-month physical therapy trial, Piriformis syndrome is a common cause of low back pain and accounts for 6-8% of patients presenting with buttock pain, which may variably be associated with sciatica, due to a compression of the sciatic nerve by the piriformis muscle (behind the hip joint). Piriformis syndrome is primarily caused by fall injury, but other causes are possible, including pyomyositis, dystonia musculorum deformans, and fibrosis after deep injections. Symptoms include buttock pain and tenderness with or without electrodiagnostic or neurologic signs. Pain is exacerbated in prolonged sitting.

Specific physical findings are tenderness in the sciatic notch and buttock pain in flexion, adduction, and internal rotation (FADIR) of the hip. Imaging modalities are rarely helpful, but electrophysiologic studies should confirm the diagnosis, if not immediately, then certainly in a patient re-evaluation and as such should be sought persistently. Physical therapy aims at stretching the muscle and reducing the vicious cycle of pain and spasm. It is a mainstay of conservative treatment, usually enhanced by local injections. Surgery should be reserved as a last resort in case of failure of all conservative modalities. No consensus exists on overall treatment of piriformis syndrome due to lack of objective clinical trials." The documentation submitted for review did not indicate that a physical therapy trial for this current exacerbation of pain has occurred. As the criteria is not met, the request is not medically necessary.