

<b>Case Number:</b>	CM15-0214834		
<b>Date Assigned:</b>	11/04/2015	<b>Date of Injury:</b>	09/04/2012
<b>Decision Date:</b>	12/16/2015	<b>UR Denial Date:</b>	10/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/02/2015

### 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 53 year old male who sustained an industrial injury on 09-04-2012. A review of the medical records indicated that the injured worker is undergoing treatment for lumbar facet (L4-S1) arthropathy and bilateral sacroiliac (SI) joint dysfunction. According to the treating physician's progress report on 10-06-2015, the injured worker continues to experience low back pain rated at 6-8 out of 10 with medications and 9 out of 10 on the pain scale without medications. Observation noted a normal gait with normal heel-toe swing through gait without evidence of a limp and no evidence of weakness walking on the toes or heels. Examination demonstrated normal lordosis with tenderness to palpation of the paravertebral muscles bilaterally. There was no evidence of tenderness over the bilateral sacroiliac joints, sciatic notches, flanks or coccyx. Straight leg raise was negative at 90 degrees bilaterally. There was decreased sensation over the left L5 dermatome distribution. Deep tendon reflexes of the knees were 1+ bilaterally and absent bilaterally at the ankles. Motor strength at hip flexion bilaterally and left extensor hallucis longus muscle was noted at 4+ out of 5 with other muscles groups at 5 out of 5. Vascular status was intact. Provocative sacroiliac joint test were positive for thigh thrust, Fortin's and compression signs. Prior treatments have included bilateral sacroiliac joint injections under fluoroscopic guidance in 11-10-2014. According to the progress report dated 10-06-2015, documentation stated "prior sacroiliac joint block provided 90% relief of symptoms that gradually returned over a six week period". Current medications were listed as Norco 10mg-325mg, Tramadol and medications for hypertension and diabetes mellitus. Treatment plan consists of Movantik, continuing Tramadol and Norco and the current request for bilateral sacroiliac (SI) joint radiofrequency ablation, Qty: #1. On 10-14-2015, the Utilization Review determined the request for bilateral sacroiliac joint radiofrequency ablation, Qty: #1 was not medically necessary.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Radiofrequency ablation bilateral at SI joint Qty: 1.00: 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), Sacroiliac joint radiofrequency neurotomy.

**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 Sacroiliac radiofrequency neurotomy, 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 at least 3 positive specific tests for motion palpation and pain provocation for SI joint dysfunction, none have been demonstrated on medical reports submitted without tenderness over SI joints and with radiculopathy findings of decreased motor strength, DTRs and sensation. 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 clearly defined symptom complaints, documented specific clinical findings or met the guidelines criteria with ADL limitations or failed conservative treatment trials for this chronic 2012 injury. Guidelines states SI radiofrequency neurotomy as not recommended due to a lack of evidence supporting this technique and that current treatment remains investigational as more research is needed to refine the technique of SI joint denervation, better assess long-term outcomes, and to determine what combination of variables can be used to improve candidate screening. The Radiofrequency ablation bilateral at SI joint Qty: 1.00 is not medically necessary or appropriate.