MAXIMUS Federal Services

Case Number:	CM15-0216338		
Date Assigned:	11/05/2015	Date of Injury:	04/17/2012
Decision Date:	12/30/2015	UR Denial Date:	10/19/2015
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: Massachusetts
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 54-year-old female who sustained an industrial injury on 4-17-12. A review of the medical records indicates that the worker is undergoing treatment for sacroilitis not elsewhere classified, postlaminectomy syndrome-lumbar, cervical radiculitis, lumbosacral spondylosis, lumbosacral neuritis not otherwise specified and is status post L4-L5 fusion with rods, screws and bone extenders with a cage on 6-11-15. Subjective complaints (10-12-15) include increased pain in the lower back since the last visit, pain in the joints in the low back and difficulty with sleep. Pain is rated at 4 out of 10. Work status was noted as not currently working. Objective findings (10-12-15) include an antalgic gait, tenderness to palpation over the right and left lumbar facets and right and left sacroiliac joint, seated straight leg raise is negative, increased lumbar lordosis with tenderness the entire lower lumbosacral region, and positive Kemps and Patricks. An MRI (6-2-14) of the lumbar spine reveals Grade 0-1 spondylolisthesis of L4 upon L5 with mild bilateral lateral recess stenosis more so on the right side. Previous treatment includes physical therapy, SI (sacroiliac) injection (with reported immediate 100% relief), medication, transcutaneous electrical nerve stimulation, and acupuncture. The requested treatment of bilateral sacroiliac L5 DR (Dorsal Ramus) injection was non-certified on 10-19-15.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral sacroiliac L5 DR injection due to pain over the SI joints and positive Patrick's bilaterally: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back-Lumbar & Thoracic -Sacroiliac joint injections (SJI); ODG, Hip & Pelvis (Acute & Chronic), Sacroiliac injections, diagnostic.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Hip/Pelvis, Sacroiliac Injection.

Decision rationale: Recommended as an option if failed at least 4-6 weeks of aggressive conservative therapy as indicated below. 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). 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). (Schwarzer, 1995) 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. Sacral lateral branch injections have demonstrated a lack of diagnostic power and area not endorsed for this purpose. (Yin, 2003) Treatment: 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-inflammatory) 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. (Forst, 2006) (Berthelot, 2006) (van der Wurff, 2006) (Laslett, 2005) (Zelle, 2005) (McKenzie-Brown 2005) (Pekkafahli, 2003) (Manchikanti, 2003) (Slipman, 2001) (Nelemans-Cochrane, 2000) See also Intra-articular steroid hip injection; & Sacroiliac joint radiofrequency neurotomy. Recent research: A systematic review commissioned by the American Pain Society (APS) and conducted at the Oregon Evidence-Based Practice Center states that there is insufficient evidence to evaluate validity or utility of diagnostic sacroiliac joint block, and that there is insufficient evidence to adequately evaluate benefits of sacroiliac joint steroid injection. (Chou, 2009) The latest AHRQ Comparative Effectiveness Report, covering Pain Management Interventions for Hip Fracture, concluded that nerve blockade was effective for relief of acute pain; however, most studies were limited to either assessing acute pain or use of additional analgesia and did not report on how nerve blockades may affect rehabilitation such as ambulation or mobility if the blockade has both sensory and motor effects. 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 injured worker 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. According to the documents available for review, the IW does meet the ODG requirements for use of sacroiliac injection. Therefore, at this time, the requirements for treatment have been met and medical necessity has been established. Therefore, this request is medically necessary.