

<b>Case Number:</b>	CM15-0119339		
<b>Date Assigned:</b>	06/29/2015	<b>Date of Injury:</b>	01/15/1996
<b>Decision Date:</b>	07/28/2015	<b>UR Denial Date:</b>	05/25/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/19/2015

### 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 55 year old female, who sustained an industrial injury on 1/15/96. The injured worker has complaints of neck pain, low back pain and shoulder pain. Low back/lumbar examination noted tenderness with palpation of the S1 (sacroiliac) joint and the lumbar range of motion is slightly diminished with extension. The diagnoses have included neck pain, lumbar pain, left shoulder pain; rotator cuff tear and cervical and lumbar disk bulge. Treatment to date has included magnetic resonance imaging (MRI) of the shoulder, cervical and lumbar spine taken on 5/22/15 shows prior arthroscopy of the left shoulder, full-thickness articular sided supraspinatus tear, lumbar spine showed degenerative disc disease with 3 to 4 millimeter posterior disk protrusion, facet arthropathy resulting in mild to moderate bilateral stenosis of lateral recess and there is impingement upon the exiting left and right C7 nerve root; physical therapy; transcutaneous electrical nerve stimulation unit; pain medications; shoulder surgery; multiple back procedures; epidural treatment to the back; botox injection for the neck and removal part of the clavicle. The request was for bilateral sacroiliac joint injection.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Bilateral sacroiliac joint injections:** 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), Hip & Pelvis Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Hip Chapter, SI Joint, 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. 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, failed conservative treatment trials for this chronic injury. The Bilateral sacroiliac joint injections is not medically necessary and appropriate.