

<b>Case Number:</b>	CM14-0136014		
<b>Date Assigned:</b>	09/03/2014	<b>Date of Injury:</b>	10/13/2013
<b>Decision Date:</b>	10/02/2014	<b>UR Denial Date:</b>	08/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/22/2014

### 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. The expert reviewer is Board Certified in Anesthesiologist and Pain Medicine, and is licensed to practice in Florida. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 51 year-old female who reported a work related injury on 10/13/2013 due to repetitive movement which consisted of lifting, pulling, twisting, bending, and standing for long periods of time. The diagnoses consisted of sacroiliitis, degeneration of the lumbar disk, facet joint syndrome of the lumbar spine, and low back pain. Prior treatment has included physical therapy, bed rest, medications, chiropractic care, pain management, massages, and a home exercise program. The diagnostic tests included an MRI dated 07/23/2014 of the lumbar spine which revealed degenerative disc and facet changes in the lower lumbar spine. The only surgical history the injured worker had was a tonsillectomy. Upon examination on 07/24/2014, the injured worker complained of pain to the right side axial low back, right buttocks, and to the right lower extremity. It was also noted the injured worker had radiation of pain to the right lower extremity. The injured worker rated his pain as a 3/10 on the VAS pain scale and that it was continuous and intermittent. The lumbar spine was inspected and revealed full flexion without pain, and decreased bilateral lateral flexion with pain. There was tenderness to the paravertebrals which was greater on the right and point tenderness to the SI joint with a positive fabers test. The treatment plan was for a Right Sacroiliac Joint Injection with Ultrasound Guidance, Oral Sedation, and a Post Procedure Follow-Up. The rationale for the request and the request for authorization form were not submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right Sacroiliac Joint Injection with Ultrasound Guidance and Oral Sedation: 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, and Pelvis, Sacroiliac Joint Blocks

**Decision rationale:** The request for Right Sacroiliac Joint Injection with Ultrasound Guidance and Oral Sedation is not medically necessary. The Official Disability Guidelines state sacroiliac joint blocks are recommended as an option after the failure of at least 4-6 weeks of aggressive conservative therapy including physical therapy, home exercise, and medication management. Although the documentation provided show evidence of physical therapy, bed rest, medications, chiropractic care, pain management, massages, and a home exercise program, the documentation for these therapies was not provided, which does not allow for a clear assessment of the conservative services provided. Additionally, the history and physical findings should suggest the diagnosis with at least 3 positive orthopedic test findings. The only positive test noted was a fabers test. In addition, the rationale for the request for sedation was not provided. As such, the request for right sacroiliac joint injection with ultrasound guidance and oral sedation is not medically necessary.

**Post-Procedure Follow-Up visit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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

**Decision rationale:** The Primary request for Sacroiliac Joint Injection with Ultrasound Guidance and Oral Sedation was deemed to not be medically necessary. As such, the request for a Post-Procedure Follow-Up Visit for the Sacroiliac Joint Injection is not medically necessary.