

<b>Case Number:</b>	CM14-0169786		
<b>Date Assigned:</b>	10/20/2014	<b>Date of Injury:</b>	10/10/2010
<b>Decision Date:</b>	11/20/2014	<b>UR Denial Date:</b>	09/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/14/2014

### 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 Physical Medicine and Rehabilitation and Pain Management, has a subspecialty in Interventional Spine and is licensed to practice in California. 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 patient is a 50-year-old female with a date of injury of 10/10/2010. The listed diagnoses per [REDACTED] are: 1. Pain in joint of lower leg. 2. Reflex sympathetic dystrophy of lower limb. 3. Thoracic or lumbosacral neuritis or radiculitis. 4. Arthropathy, not otherwise specified, of lower leg. According to progress report 08/28/2014, the patient complains of multiple joint pain. The pain is characterized as aching and stabbing and radiates to the left hip and left knee. Examination of the lower back revealed restrictive range of motion with limited flexion to 40 degrees and extension limited to 5 degrees by pain. On palpation, paravertebral muscles and tenderness was noted on the left side. Spinous processes tenderness is noted at L3 to L5 levels. Straight leg raise test is negative on both sides. Examination of the right knee revealed tenderness to palpation over the lateral joint line. Examination of the left knee revealed decreased range of motion with flexion limited to 110 degrees limited by pain. Tenderness to palpation is noted over the lateral joint line, medial line, patella, and quadriceps tendon. The treating physician is requesting SI joint injection of the left sacroiliac joint and MRI of the left knee. Utilization review denied the request at 09/17/2014. Treatment reports from 04/17/2014 to 09/19/2014 were reviewed.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**(1) SI Joint Injection of left sacroiliac joint:** 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) SI joint injections under its Pelvic/Hip chapter

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) SI joint injections under its Pelvic/Hip chapter

**Decision rationale:** This patient presents with low back and bilateral knee pain. The treating physician is requesting a Sacroiliac Joint (SI) joint injection of the left sacroiliac joint since "the patient needs the criteria for the use of sacroiliac joint injections according to ODG Guidelines." ODG guideline has the following regarding SI joint injections under its Pelvic/Hip chapter: SI joint injections are not supported without objective findings consistent with sacroiliitis. ODG further states, "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..." The reports provided do not document 3 positive exam findings as required by MTUS. Furthermore, the patient has diagnosis of thoracic or lumbosacral neuritis or radiculitis which is not consistent with SI joint syndrome. The request is not medically necessary and appropriate.

**(1) MRI of left knee without contrast:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee & Leg (Acute & Chronic)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) under its Knee Chapter regarding MRI

**Decision rationale:** This patient presents with low back and bilateral knee complaints. The treating physician is requesting an MRI of the left knee to "rule out any structural pathology that might require surgery. ODG-TWC guidelines under its Knee Chapter has the following regarding MRI: "Recommended as indicated below. Soft-tissue injuries (meniscal, chondral surface injuries, and ligamentous disruption) are best evaluated by MRI." Review of the reports do not show that this patient has had an MRI done before. In this case, the treater states that the patient requires an MRI of the left knee as the patient reports ongoing symptoms of pain and decrease in function. It would appear that the patient has failed with conservative care and given no prior MRI, an imaging study appears reasonable and medically indicated. The request is medically necessary and appropriate.