

<b>Case Number:</b>	CM14-0020878		
<b>Date Assigned:</b>	04/30/2014	<b>Date of Injury:</b>	07/09/2008
<b>Decision Date:</b>	07/08/2014	<b>UR Denial Date:</b>	01/31/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/19/2014

### 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 Anesthesiology, has a subspecialty in 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 an injury due to a fall on 02/21/2007. The clinical note dated 03/04/2014 indicated diagnoses of right sacroilitis, possibility of right lumbar radiculopathy, myofascial pain, chronic low back pain, right hip pain, status-post left knee partial meniscectomy, bilateral knee pain and degenerative joint disease to the bilateral knees. The injured worker reported low back pain of 8/10 in severity that radiated down her right lower extremity. She also reported right knee pain. On physical exam, there was tenderness at the right posterior superior iliac spine and lumbar facet joints bilaterally. There were spasms in the lumbar paraspinous muscle and stiffness on the lumbar spine. There was antalgic gait on the right, dysesthesia to light touch in the right L5 more so than the S1 dermatome. The medication regimen included hydrocodone, trazadone, cyclobenzaprine and lidocaine. The request for authorization was submitted on 12/17/2013.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **RIGHT SACROILIAC JOINT INJECTION X1: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Hip & Pelvis Chapter, Sacroiliac Joint Injections.

**Decision rationale:** The injured worker diagnoses is right sacroilitis, possibility of right lumbar radiculopathy, myofascial pain, chronic low back pain, right hip pain, status-post left knee partial meniscectomy, bilateral knee pain and degenerative joint disease to the bilateral knees. The ODG recommend the sacroiliac joint injection as an option if failed at least 4-6 weeks of aggressive conservative therapy. There is lack of evidence in the injured worker's records of conservative treatment such as physical therapy. ODG also recommend documentation of at least 3 positive exam findings. The physical exam failed to reveal at least 3 orthopedic tests consistent with SI joint dysfunction. Therefore, the request for right sacroiliac joint injection is not medically necessary.