

<b>Case Number:</b>	CM14-0035561		
<b>Date Assigned:</b>	06/23/2014	<b>Date of Injury:</b>	06/22/1994
<b>Decision Date:</b>	07/18/2014	<b>UR Denial Date:</b>	02/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/24/2014

### 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, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 69 year old female with reported injury on 06/22/1994. The mechanism of injury was not provided. The injured worker had a review of exam on 01/31/2014 with complaints of right low back pain which radiates to her right buttock and posterior upper thigh, and complaints of her right lower scapula intramuscular pain. The exam showed motor strength to lower extremities as a 5/5. Her sensation is normal to light touch. Straight leg raise test was negative to 70 degrees in the sitting and supine positions. The femoral stretch test was negative bilaterally. The hips had full range of motion without pain. The injured worker had a positive compression test and positive FABER test. The cervical spine and upper extremity strength was a 5/5 bilaterally. The Hoffmann and Spurling's signs were negative. There was not a medication list provided. The diagnoses consisted of right sacroiliac joint strain and right upper thoracic intramuscular pain. The plan of treatment was to consider cortisone injections in the right sacroiliac joint and right upper thoracic spine. The request for authorization was signed on 02/13/2014. The rationale was not provided.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Sacroiliac joint injection:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, hip and pelvis, sacroiliac joint blocks.

**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 Chapter, Sacroiliac joint injection.

**Decision rationale:** The request for sacroiliac joint injection is non-certified. The Official Disability Guidelines recommend the injection as an option if failed at least four to six weeks of aggressive conservative therapy. There was no evidence of conservative therapy to include: medications and efficacy, physical therapy or home exercise program. There was lack of documentation provided to support the need for a sacroiliac joint injection, therefore the request is non-certified.

**Intramuscular thoracic/scapular injection:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, pain, injection with anesthesia and/or steroids.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck, steroid injection.

**Decision rationale:** The request for intramuscular/ scapular injection is non-certified. The Official Disability Guidelines recommends the steroid injection if pain is not controlled by conservative treatments such as physical therapy, exercise, and NSAIDS after three months. There is lack of evidence of physical therapy and exercise. There was not a medication list and efficacy provided. The guidelines also recommend injections if the pain interferes with functional activities. There was a lack of documentaton regarding functional deficits. There was a lack of evidence to support the need for the injection, therefore the request is non-certified.