

<b>Case Number:</b>	CM14-0065390		
<b>Date Assigned:</b>	07/11/2014	<b>Date of Injury:</b>	02/17/2005
<b>Decision Date:</b>	08/08/2014	<b>UR Denial Date:</b>	04/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/08/2014

### 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 & Rehabilitation, 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 male with date of injury of 02/17/2005. The listed diagnoses per [REDACTED] dated 04/01/2014 is lumbosacral spondylosis with myelopathy and limb pain. According to this report, the patient complains of back pain, thoracic pain that is aggravated with movement and activity. The patient currently takes Motrin. The physical exam shows the patient is alert and oriented. Speech is normal. Pupils are reacting equal and reactive. Shoulder shrug was normal. Gait is normal. No other findings were noted on this or other reports provided. The utilization review denied the request on 04/28/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right SI 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 (ODG), Hip & pelvis chapter.

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

**Decision rationale:** This patient presents with back and thoracic pain. The treater is requesting a right SI joint injection. The MTUS and ACOEM Guidelines do not address sacroiliac joint injections, however, the Official Disability Guidelines (ODG) recommends SI joint injections as an option if the patient has 3 positive exam findings for SI joint syndrome; diagnostic evaluation have addressed other possible pain generators; failed at least 4 to 6 weeks of aggressive conservative therapy including physical therapy, home exercise, and medication management. None of the 39 pages of reports provided document 3 positive SI joint examination, evaluation for other pain generators and documentation of failed conservative therapy. In this case, the patient has failed to meet the criteria required by MTUS for an SI joint injection. Recommendation is not for medical necessity.