

Case Number:	CM14-0166862		
Date Assigned:	10/14/2014	Date of Injury:	10/09/1999
Decision Date:	09/01/2015	UR Denial Date:	09/09/2014
Priority:	Standard	Application Received:	10/09/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Colorado
 Certification(s)/Specialty: Family Practice

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 62 year old male, who sustained an industrial injury on 10/9/99. The diagnoses have included lumbar disc displacement, lumbosacral spondylosis, neck pain and pain in the thoracic spine. Treatment to date has included medications, activity modifications, injections and other modalities. Currently, as per the physician progress note dated 9/3/14, the injured worker complains of neck and back pain. The objective findings reveal antalgic gait and positive Patrick's maneuver on the right and positive sciatic notch tenderness on the right. The current pain medications included Celebrex, Capsaicin cream, Hydrocodone/APAP, Orphenadrine-Norflex, Protonix, and Opana. There was no previous diagnostic report noted and no previous therapy sessions noted. The physician noted that the injured worker has facet mediated pain and sacroiliac joint pain and has had some response to injections in the past. Work status is permanent and stationary. The physician's requested treatment included Right Sacroiliac Joint Injection with arthrogram under fluoroscopic guidance and intravenous sedation.

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 arthrogram under fluoroscopic guidance and IV sedation: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines-Work Loss Data\Institute LLC Corpus Christi TX; Hip and Pelvis.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 611-612.

Decision rationale: The MTUS does not address SI joint injections, so the ACOEM was consulted. Per the ACOEM, SI joint injections are recommended when patient has a known inflammatory arthropathy of the SI joint. SI joint injections with or without use of fluoroscopy, are not recommend for acute or subacute or chronic low back pain not related to an inflammatory arthropathy for the patient of concern, only a single clinic note was included for our review, so there was no documentation available that included imaging results, PT notes, previous injection information and detailed outcomes, or other information about patient condition. Without appropriate documentation of patient condition and treatments to date, and without documented inflammatory arthropathy, the SI joint injection is not medically necessary.