

<b>Case Number:</b>	CM14-0204453		
<b>Date Assigned:</b>	12/16/2014	<b>Date of Injury:</b>	07/17/1996
<b>Decision Date:</b>	02/12/2015	<b>UR Denial Date:</b>	11/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/08/2014

### 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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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 year 74 old male who was injured on 7/17/1996. The diagnoses are sacroilitis, trochanter bursitis, low back pain and piriformis syndrome. There is a past surgical history of L4-L5 posterior laminectomy. The 1999 MRI of the lumbar spine showed L4-L5 disc bulge, epidural fibrosis, facet arthropathy, canal stenosis and degenerative disc disease. On 10/7/2014, [REDACTED] / [REDACTED] noted a pain score of 7/10 on a scale of 0 to 10. The oral medications was noted to be no longer effective in controlling the pain. There was objective finding of severe tenderness to palpation of bilateral sacroiliac joints, piriformis muscles and greater trochanter. The FABER test was positive bilaterally. The lower extremities examination was normal. The medications listed are Norco, Tizanidine and Tramadol. A Utilization Review Determination was rendered on 11/24/2014 recommending non certification for left sacroiliac joint injection, piriformis muscle injection and greater trochanter injection.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left sacroiliac (SI) joint injection, piriformis muscle injection and greater trochanter injection:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM [www.acoempracguides.org/low back; Low Back Disorders](http://www.acoempracguides.org/low%20back;Low%20Back%20Disorders)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Hip and Pelvis

**Decision rationale:** The CA MTUS and the ODG guidelines recommend that interventional pain procedures can be utilized for the treatment of musculoskeletal pain when conservative treatments with medications and PT have failed. The records indicate that the patient had exacerbation of low back pain despite medications management. There are subjective and objective findings indicative of bilateral sacroiliac joints pain. The differential diagnoses of sacroiliac joint, piriformis and greater trochanter pain have many subjective and objective findings in common. The guidelines recommend that interventional procedures be limited to the treatment of each diagnosis separately so that efficacy of the procedures can be properly evaluated. The criteria for the combined left sacroiliac joint, piriformis muscle and greater trochanter injections was not met.