

<b>Case Number:</b>	CM15-0006268		
<b>Date Assigned:</b>	01/26/2015	<b>Date of Injury:</b>	01/14/2013
<b>Decision Date:</b>	03/24/2015	<b>UR Denial Date:</b>	12/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/12/2015

### 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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 50 year old male, who sustained an industrial injury on 01/14/2013. He has reported neck, low back and right shoulder pain and was diagnosed with low back pain with radicular symptoms to the right lower extremity, right shoulder labral tear with impingement and right sacroiliac joint arthropathy. Treatment to date has included oral medication and physical therapy. In a progress note from 11/20/2014, the injured worker was complaining of occasional neck pain rated as 8/10, constant right shoulder pain rated as 8-9/10 and constant mid and low back pain rated as 8/10. The injured worker was having difficulty performing activities of daily living as a result of his symptoms. Objective physical examination findings were notable for right sided tenderness of the lumbar spinous processes, posterior superior iliac space and the sacroiliac and facet joints. Straight leg raise was noted to produce pain in the supine position and there was reduced range of motion of the lumbar spine with spasm. The physician noted that a request was being made for authorization of a right sacroiliac joint steroid injection under fluoroscopy as the injured worker had not responded to conservative treatment of symptoms. On 01/14/2013, Utilization Review non-certified a prospective request for one right sacroiliac joint steroid injection under fluoroscopy between 12/5/2014-01/19/2015 noting that there was no evidence of a trial of aggressive conservative treatment prior to ordering the injection. ACOEM and ODG guidelines were cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right Sacroiliac Joint Steroid Injection Under Fluoroscopy: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ESI.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 196-197.

**Decision rationale:** The claimant is more than two years status post work-related injury and continues to be treated for symptoms including low back pain. The requesting provider documents tenderness over multiple right lumbar structures. Guidelines recommend against sacroiliac joint injections for subacute or chronic nonspecific low back pain, including pain attributed to the sacroiliac joints, without evidence of inflammatory sacroiliitis (rheumatologic disease). In this case, there is no evidence by imaging or lab testing or by history of an inflammatory spondyloarthropathy and therefore the requested left sacroiliac joint injection is not medically necessary.