

<b>Case Number:</b>	CM15-0186905		
<b>Date Assigned:</b>	09/28/2015	<b>Date of Injury:</b>	01/12/2015
<b>Decision Date:</b>	11/06/2015	<b>UR Denial Date:</b>	09/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/22/2015

### 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: Arizona, California  
 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 55 year old female who sustained an industrial injury on 1-12-2015. A review of medical records indicates the injured worker is being treated for hip bilateral, sacroiliac pain, low back pain, arthritis of the back, and arthropathy of sacroiliac joint. Medical records dated 8-19-2015 noted right sided low back pain. Current pain was rated a 3 out 10. Average pain was a 5 out 10. Pain score without medication is a 7 out 10 and with medication a 2 out 10. Worst pain is a 9 out 10. She had increased pain with bending backward, sitting, standing, walking stairs, exercise, coughing, lying down, sexual relation, and functional limitations, which she avoids. Physical examination noted bilateral lumbar tenderness with pain. There was restricted range of motion with pain. Treatment has included physical therapy, medications, cold, heat, ice therapy, and chiropractic care. Utilization review form dated 9-16-2015 noncertified sacroiliac joint belt.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Sacroiliac Joint Belt:** 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, Sacroiliac support belt.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Initial Care, Physical Methods, Summary. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip chapter and pg 20.

**Decision rationale:** According to the ACOEM guidelines, injections are not recommended. Invasive techniques are of questionable merit. The treatments do not provide any long-term functional benefit or reduce the need for surgery. The ODG guidelines recommend hip injections for bursitis. Injections are not recommended for arthritis. The claimant does not have bursitis but does have arthritis. Therefore, the request for SI joint injection is not medically necessary.