

Case Number:	CM15-0220359		
Date Assigned:	11/16/2015	Date of Injury:	08/31/2000
Decision Date:	12/23/2015	UR Denial Date:	11/05/2015
Priority:	Standard	Application Received:	11/10/2015

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: California, Oregon, Washington
 Certification(s)/Specialty: Orthopedic Surgery

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 female, who sustained an industrial injury on 8-31-2000. The injured worker is being treated for lumbar radiculopathy, knee pain and pain in joint lower leg. Treatment to date has included extensive treatment for the left knee, and subsequent compensatory right knee pan followed by interventions for the right knee including surgery. Treatment for both knees and the back have also included aqua therapy, physical therapy, injections of the right and left knees, diagnostics and orthopedic and pain management evaluations. On 6-19-2015 and 7-17-2015 the injured worker reported lower backache, bilateral knee pain and left hip pain. Inspection of the hip revealed restricted range of motion with flexion and internal and external rotation-more painful with external rotation. FABER test was positive. On 8-07-2015 she reported lower backache and left hip pain rated as 4 out of 10 with medications and 9 out of 10 without medications. The hip exam was unchanged from 6-19-2015 and 7-17-2015. Per the most recent orthopedic exam dated 9-21-2015 she reported increasing left hip pain. She cannot sleep on the left side. There is no physical exam recorded for this date. There is no documentation of improvement in symptoms, increase in activities of daily living or decrease in pain level with the current treatment. Work status was "permanent and stationary." The plan of care included a knee brace and medications. On 11-05-2015, Utilization Review non-certified the request for bilateral sacroiliac joint injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral Sacroiliac 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).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip and Pelvis / Sacroiliac injections, diagnostic & therapeutic.

Decision rationale: CA MTUS/ACOEM is silent on the issue of sacroiliac joint injection. According to ODG Hip and Pelvis / Sacroiliac injections, diagnostic & therapeutic: Not recommended, including sacroiliac intra-articular joint and sacroiliac complex diagnostic injections/blocks (for example, in anticipation of radiofrequency neurotomy). Diagnostic intra-articular injections are not recommended (a change as of August 2015) as there is no further definitive treatment that can be recommended based on any diagnostic information potentially rendered (as sacroiliac therapeutic intra-articular injections are not recommended for non-inflammatory pathology). Consideration can be made if the injection is required for one of the generally recommended indications for sacroiliac fusion. Not recommend therapeutic sacroiliac intra-articular or periarticular injections for non-inflammatory sacroiliac pathology (based on insufficient evidence for support). Recommend on a case-by-case basis injections for inflammatory spondyloarthropathy (sacroiliitis). This is a condition that is generally considered rheumatologic in origin (classified as ankylosing spondylitis, psoriatic arthritis, reactive arthritis, arthritis associated with inflammatory bowel disease, and undifferentiated spondyloarthropathy). Instead of injections for non-inflammatory sacroiliac pathology, conservative treatment is recommended. In this case there is no indication for either diagnostic or therapeutic sacroiliac joint injection. This patient does not have a diagnosis of inflammatory spondyloarthropathy (sacroiliitis). This patient does not meet ODG criteria for consideration for sacroiliac fusion. Thus the proposed injection is not medically necessary and the recommendation is for non-certification.