Case Number:	CM15-0051868		
Date Assigned:	03/25/2015	**Date of Injury:**	09/05/2014
Decision Date:	05/08/2015	**UR Denial Date:**	03/11/2015
Priority:	Standard	**Application Received:**	03/19/2015

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: New Jersey
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 58 year old female, who sustained an industrial injury on 09/05/2014. She reported coccyx pain and a burning sensation to the right side of the coccyx. She was referred to physical therapy and was prescribed Lodine, Norco, Voltaren Gel and Zostrix. She had also taken Chinese herbs and acupuncture. According to an initial consultation dated 02/25/2015, the injured worker reported sacrococcygeal and coccyx pain and bilateral buttock pain. Pain was rated 8-9 on a scale of 1-10. Physical therapy was noted as no help. Current medications included Norco and Flexeril. Diagnoses included coccydynia, coccyx pain, sacrococcygeal pain, bilateral buttock pain, lumbar disc herniation, lumbar radiculopathy and lumbar stenosis. Treatment recommendations included a fluoroscopically guided sacrococcygeal and coccygeal steroid injection. The provider noted that physical therapy and nonsteroidal anti-inflammatory drugs had failed to treat her severe sacrococcygeal and coccygeal pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fluoroscopically guided sacrococcygeal and coccygeal steroid injection: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation http://www.mdguidelines.com/coccydynia.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Patel R, Appannagari A, Whang PG. Coccydynia. Current Reviews in Musculoskeletal Medicine. 2008;1(3-4):223-226. doi:10.1007/s12178-008-9028-1.

Decision rationale: The MTUS Guidelines and ODG both do not address coccygeal steroid injections. Other resources were searched for, and an article review on the subject of coccydynia from 2008 was used as a reference. It stated that local injections with fluoroscopic guidance (preferred) into the region of the coccyx represent another therapeutic approach for managing coccydynia refractory to other nonoperative techniques such as NSAIDs and manipulation. Also, one study suggested injection with steroid combined with manipulation produced greater success than injection alone. Some practitioners suggest that the first line of treatment for coccydynia should include at least 8 weeks of rest, stool softeners, adjustments in sitting position, and NSAIDs. Acute coccydynia refractory to these therapies or chronic symptoms lasting greater than 2 months should be further evaluated with dynamic radiographs and MRI of the coccyx. Additional nonoperative modalities such as massage, stretching, or injections may also be incorporated at this time. Nevertheless, patients who fail to respond to these conservative therapies may be considered to be reasonable candidates for surgical intervention. In the case of this worker, there was documentation of chronic sacrococcydynia which essentially failed conservative care. However, there was no record which showed imaging such as MRI was performed to rule out occult fracture or other abnormalities before considering an intervention such as an injection as requested. Therefore, after MRI is performed, in the opinion of the reviewer, injection might be reasonable and justified. As for now, without evidence of this imaging, the request for injection will be considered medically unnecessary.