

<b>Case Number:</b>	CM14-0130437		
<b>Date Assigned:</b>	08/20/2014	<b>Date of Injury:</b>	01/17/1996
<b>Decision Date:</b>	09/24/2014	<b>UR Denial Date:</b>	08/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/15/2014

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 injured worker is a 42-year-old female who reported an injury on 01/17/1996. The mechanism of injury was not provided. On 01/02/2014, the injured worker presented with low back pain that radiates down the right leg. Upon examination of the lumbar spine, there was tenderness to palpation over the L4-5 facets and L5 facet with pain. It was a positive right sided Faber's test. Diagnoses were lumbago and right sacroiliitis. Prior therapy included medications and injections. The provider recommended a sacrococcygeal injection. The provider's rationale was not provided. The Request for Authorization form was not included in the medical documents for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 Sacrococcygeal Injection x1, as an outpatient:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Hip and Pelvis.

**Decision rationale:** The request for a sacrococcygeal injection x1 as an outpatient is not medically necessary. The Official Disability Guidelines state sacrococcygeal injections are not recommended. It is under study for moderately advanced or severe hip osteoarthritis. It is also recommended as an option for short-term pain relief of hip trochanteric bursitis. There is a lack of documentation that the injured worker has a diagnosis congruent with the guideline recommendations for sacrococcygeal injections. Additionally, there is a lack of documentation indicating the prior courses of conservative care and efficacy of the prior treatments provided in the medical documents for review. As such, the medical necessity has not been established.