

<b>Case Number:</b>	CM14-0147218		
<b>Date Assigned:</b>	09/15/2014	<b>Date of Injury:</b>	08/28/1996
<b>Decision Date:</b>	10/15/2014	<b>UR Denial Date:</b>	08/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/10/2014

### 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 and is licensed to practice in California. 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 58-year-old male who reported injury on 08/28/1996. The mechanism of injury was not submitted for review. The injured worker has diagnosis of lumbago of the spine. Past medical treatment consists of surgery, use of TENS unit, physical therapy and medication therapy. On 07/02/2014 the injured worker underwent lumbar spine radiograph which revealed status posterior decompression, anterior and posterior fusion from L2-5 with intervertebral spacers with satisfactory alignment. On 09/19/2014 the injured worker complained of lower back pain. The examination revealed that the hips/pelvis range of motion was a flexion of 100 degrees bilaterally. Spine extension to the right was 15%, flexion to the right was 40%, rotation to the left was 45%, rotation to the right was 50%, side bending to the left was 50% and side bending to the right was 50%. The medical treatment plan is for the injured worker to undergo an SI joint injection. The rationale and Request for Authorization form were not submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**A request for a right sacroiliac joint injection Quantity: 1.00: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guideline (ODG)

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

**Decision rationale:** The request for a right sacroiliac joint injection is not medically necessary. The Official Disability Guidelines recommend sacroiliac joint blocks when the history and physical suggest the diagnoses with documentation of at least 3 positive exam findings include the cranial shear test, extension test, flamingo test, Gaenslen's test, Gillet's test, Patrick's test, pelvic compression test, pelvic distraction test, pelvic rock test, resisted abduction test, sacroiliac shear test, standing flexion test and a thigh thrust test. Diagnostic evaluation must first address any noted possible pain generators and there should be documentation that the injured worker has failed at least 4 to 6 weeks of aggressive/conservative therapy including physical therapy, home exercise and medication management. In the treatment and therapeutic phase, the suggested frequency for repeat blocks is 2 months or longer between each injection, provided that at least 70% of pain relief is obtained for 6 weeks. The physical examination dated 09/09/2014 did not indicate that the injured worker had at least 3 of the above test positive to suggest diagnoses. Furthermore, there was no indication in the submitted report that the injured worker had trialed and failed at aggressive/conservative therapy for at least 4 to 6 weeks. Given the above, the injured worker is not within ODG criteria. As such, the request for a Right Sacroiliac Joint Injection is not medically necessary.

**One request for an ultrasound guidance for injection:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** As the requested surgical intervention is not supported by the documentation, the requested ancillary service is also not supported. Therefore, the request for Ultrasound Guidance For Injection is not medically necessary.