

<b>Case Number:</b>	CM14-0177974		
<b>Date Assigned:</b>	10/31/2014	<b>Date of Injury:</b>	11/11/2012
<b>Decision Date:</b>	12/24/2014	<b>UR Denial Date:</b>	10/20/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/27/2014

### 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 Internal Medicine and is licensed to practice in Maryland. 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 employee was a 48 year old male who sustained an industrial injury on 11/11/12 to his back from wearing a heavy duty belt. His prior lumbar spine MRI from 02/16/12 revealed small posterior disc protrusion at L5-S1 with small posterior annular tear, moderate facet hypertrophy with small facet spur that mildly effaced the left exiting nerve root, bilateral mild neural foraminal stenosis, disc desiccation and minimal posterior protrusion at L2-3 without significant central canal or neural foraminal narrowing. His recent MR arthrogram of right hip was significant for diminutive/worn anterior labrum, chronic mild athletic pubalgia and gluteus minimums and medius tendinopathy. His prior treatments included right SI joint injection that improved his pain, but wore off rather quickly, facet injections at L4-5 and L5-S1 in March 2013 and right S1, S2, S3 and S4 medial branch radiofrequency neurolysis in September 2014 that improved his pain. His medications included Norco, Naproxen, Percocet, Lidoderm patch and Lunesta. The clinical note from 10/07/14 was reviewed. His complaints were left shoulder pain, diffuse low back pain and right buttock pain. He was reporting an acute episodic worsening of his chronic pain. He was requesting an office injection treatment. His pertinent diagnosis included sacroiliitis. The Orthopedic note from March 2014 had diagnoses of bilateral SI joint pain. His complaints included right sided SI joint pain that was improving with SI joint injection and left side SI joint pain. He was asked to try anti-inflammatory medications for a month and a half prior to considering the SI joint injections. He was continuing to work full duty. The request was for left SI joint injection.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left sacroiliac joint injection Qty: 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 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 Joint Block.

**Decision rationale:** The employee was a 48 year old male who sustained an industrial injury on 11/11/12 to his back from wearing a heavy duty belt. His prior lumbar spine MRI from 02/16/12 revealed small posterior disc protrusion at L5-S1 with small posterior annular tear, moderate facet hypertrophy with small facet spur that mildly effaced the left exiting nerve root, bilateral mild neural foraminal stenosis, disc desiccation and minimal posterior protrusion at L2-3 without significant central canal or neural foraminal narrowing. His recent MR arthrogram of right hip was significant for diminutive/worn anterior labrum, chronic mild athletic pubalgia and gluteus minimums and medius tendinopathy. His prior treatments included right SI joint injection that improved his pain, but wore off rather quickly, facet injections at L4-5 and L5-S1 in March 2013 and right S1, S2, S3 and S4 medial branch radiofrequency neurolysis in September 2014 that improved his pain. His medications included Norco, Naproxen, Percocet, Lidoderm patch and Lunesta. The clinical note from 10/07/14 was reviewed. His complaints were left shoulder pain, diffuse low back pain and right buttock pain. He was reporting an acute episodic worsening of his chronic pain. He was requesting an office injection treatment. His pertinent diagnosis included sacroiliitis. The Orthopedic note from March 2014 had diagnoses of bilateral SI joint pain. His complaints included right sided SI joint pain that was improving with SI joint injection and left side SI joint pain. He was asked to try anti-inflammatory medications for a month and a half prior to considering the SI joint injections. He was continuing to work full duty. The request was for left SI joint injection. According to Official Disability Guidelines, SI joint blocks are recommended as an option if failed at least 4-6 weeks of aggressive conservative therapy and if the history and physical are suggestive of the diagnosis (with at least three examination positive findings). In this case, the employee had conservative care with medications. It is not clear if he had physical therapy recently for his left SI joint. Even though the employee had temporary relief with prior injection on the right side, the absence of detailed examination of the left SI joint and without any positive tests on examination, the request for left SI joint injection is not medically necessary or appropriate.