

<b>Case Number:</b>	CM14-0211543		
<b>Date Assigned:</b>	12/24/2014	<b>Date of Injury:</b>	07/27/2010
<b>Decision Date:</b>	03/17/2015	<b>UR Denial Date:</b>	12/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/17/2014

### 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. 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, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 47-year-old female who reported an injury on 07/27/2010. The mechanism of injury was not provided. She has a history of shoulder and lumbar pain. On 11/20/2014, the injured worker was seen for back and shoulder pain. The lumbar pain radiated bilaterally to the buttocks, right greater than left, and radiated to the top of the right foot. There was neurotomy in feet with lying down. The injured worker had coccyx pain. There was increased pain with sleeping on the side and the injured worker needed pillow for support. The injured worker had never received an injection to the SI or coccyx. Current medications include ranitidine 150 mg 1 tablet twice a day, Flexeril 7 mg 1 tablet twice a day as needed, Norco 10 mg/325 mg 1 to 2 tablets every 4 to 6 hours around the clock as needed, and Medrol pack 4 mg 1 package as directed. Upon examination the right sacroiliac joint was positive for provocative findings on lateral compression and thigh thrust. Muscle strength test was 4+/5 in the iliopsoas and quadriceps of the right side. The treatment plan was to resubmit for injection to coccyx or sacroiliac joint injection. The Request for Authorization and rationale for the request was not provided within the documentation submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right Sacroiliac Joint Injection with Fluoroscopic Guidance:** 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), Hip and Pelvis

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip & Pelvis, Intra-articular steroid hip injection (IASHI)

**Decision rationale:** The Official Disability Guidelines indicate that intra-articular steroid injections are not recommended in early hip osteoarthritis. There was a lack of documentation that the injured worker has osteoarthritis. The injured worker has a history of shoulder and lumbar pain that radiated into the buttocks, right greater than left. The portion of the request is not supported and as the intervention is not medically necessary, fluoroscopy would not be necessary. Given the above, the request for a Right Sacroiliac Joint Injection with Fluoroscopic Guidance is not medically necessary.