

<b>Case Number:</b>	CM15-0126695		
<b>Date Assigned:</b>	07/13/2015	<b>Date of Injury:</b>	04/03/2014
<b>Decision Date:</b>	08/07/2015	<b>UR Denial Date:</b>	06/01/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/30/2015

### 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: Arizona, California

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 55 year old female, who sustained an industrial injury on 4/3/2014. She reported being thrown backward. Diagnoses have included degeneration of cervical intervertebral disc, cervical spondylosis, lumbar degenerative disc disease, osteoarthritis and sacroiliitis. Treatment to date has included physical therapy, chiropractic treatment, magnetic resonance imaging (MRI) and medication. According to the history and physical exam dated 4/2/2015, the injured worker complained of neck and low back pain. She reported that chiropractic treatment was helpful. She complained of difficulty sitting. Physical exam revealed tenderness to palpation of the lumbar area. There was pain with lumbar range of motion. There was pain with facet loading on the left. There was tenderness to palpation in the left gluteus. Faber's test was positive on the left, as well as Stork. Authorization was requested for a sacroiliac joint injection on the left side.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Sacroiliac Joint Injection of the Left Side:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip chapter and pg 19.

**Decision rationale:** According to the guidelines, hip injections are recommended for bursitis but not arthritis. In this case, the claimant has sacroillitis noted and arthritis. There is no imaging indicating bursitis. As a result, the request for SI injection is not medically necessary.