

Case Number:	CM13-0037453		
Date Assigned:	12/13/2013	Date of Injury:	10/07/2010
Decision Date:	06/11/2014	UR Denial Date:	10/01/2013
Priority:	Standard	Application Received:	10/23/2013

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 Management 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:

This is a patient with a date of injury of 10/7/10. A utilization review determination dated 10/1/13 recommends not medically necessary of radiofrequency ablation of the right SI joint. 8/14/13 medical report identifies low back pain with spasms and limited ROM. Pain is 8-9/10 and radiates down from the right buttock to the right thigh. On exam, there is guarding, pain to palpation over the right SI joint with reproduction of sharp shooting pain to the thigh, SI joint thrust test is severely positive, and Gaenslen's sign, Patrick Fabere test, and Adson test are all positive. SLR is positive bilaterally. There is 4/5 weakness on the right at the quadriceps, hamstrings, and gastrocsoleus.

IMR ISSUES, DECISIONS AND RATIONALES

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

RADIOFREQUENCY ABLATION TO THE RIGHT SACROILIAC JOINT UNDER FLUOROSCOPY: 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 Chapter, Sacroiliac Joint Radiofrequency Neurotomy.

Decision rationale: Regarding the request for radiofrequency ablation to the right sacroiliac joint under fluoroscopy, California MTUS does not address the issue. ODG states that the procedure is not recommended. The use of all of these techniques has been questioned, in part, due to the fact that the innervation of the SI joint remains unclear, and there is also controversy over the correct technique for radiofrequency denervation. They also note that a recent review of this intervention in a journal sponsored by the American Society of Interventional Pain Physicians found that the evidence was limited for this procedure. In light of the above issues, the currently requested radiofrequency ablation to the right sacroiliac joint under fluoroscopy is not medically necessary.