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| Case Number: | CM14-0011819 | | |
| Date Assigned: | 02/21/2014 | Date of Injury: | 03/01/1994 |
| Decision Date: | 06/26/2014 | UR Denial Date: | 01/06/2014 |
| Priority: | Standard | Application Received: | 01/29/2014 |

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 Orthopaedic Surgery 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 patient is a 66-year-old female sustained an industrial injury on March 1, 1994. The mechanism of injury is not documented. The patient is status post right sacroiliac joint pinning and three-level anterior cervical decompression and fusion. The November 21, 2012 sacroiliac joint x-rays showed three large pins across the right sacroiliac joint, which are stable in position. Narrowing was noted at the left and right sacroiliac joints, unchanged from prior study. The November 6, 2013 treating physician report indicated that the patient was status post medial branch blocks, which gave about 4 to 5 days of relief, and has requested radiofrequency ablations, which in the past have given years' worth of relief. The December 18, 2013 chart note indicated that the radiofrequency ablations really helped her low back and improved standing tolerance. She was able to stand straighter without severe lower back pain. Bilateral buttock pain continued, left greater than right. She was trying to walk for exercise and pain was rated 3-8/10. Physical exam findings documented tenderness around the L4/5 level, moderately decreased range of motion, left antalgic gait, and positive left Gaenslen's, compression, Faber, and distraction tests. The treating physician stated that the radiofrequency ablations gave her some relief of her L4/5 instability and facetogenic pain. Left buttock pain seemed to be clearly correlating to her sacroiliac dysfunction. The December 30, 2013 surgical authorization request included left sacroiliac joint fusion with surgical services, pre-operative items, post-operative durable medical equipment, post-operative physical therapy, and home health care. The January 6, 2014 utilization review denied the left sacroiliac fusion and associated requests based on a lack of diagnostic sacroiliac joint injection and documentation of failed conservative treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

LEFT SCROILAC JOINT FUSION WITH ASSISTANT SURGEON AND ONE DAY INPATIENT STAY: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE (ACOEM), 2ND EDITION, (2004) LOW BACK DISORDERS (REVISED 2007), , 221.

Decision rationale: Under consideration is a request for left sacroiliac joint fusion with assistant surgeon and one-day in-patient stay. The ACOEM revised low back guidelines stated that sacroiliac joint fusion surgery and other sacroiliac joint surgical procedures are not recommended. The Official Disability Guidelines state that sacroiliac joint fusion is not recommended for pain, except as a last resort for chronic or severe pain, in patients who meet specific criteria. Indications for sacroiliac joint fusion include post-traumatic sacroiliac joint injury (e.g. following pelvic ring fracture), or failure of non-operative treatment, chronic pain lasting for years, and positive response to diagnostic injection. Guideline criteria have not been met. There is no indication in the records provided that the patient has severe pain that has lasted for years, and surgery is the last resort. There is no detailed documentation that recent comprehensive pharmacologic and non-pharmacologic conservative treatment had been tried and failed. There is no evidence of a positive response to diagnostic sacroiliac joint injection. Therefore, this request for left sacroiliac joint fusion with assistant surgeon and one-day in-patient stay is not medically necessary.

POST-OPERATIVE PHYSICAL THERAPY 2 X 6: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: POST-SURGICAL TREATMENT GUIDELINES, HIP, PELVIS AND THIGH, 23

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

COLD THERAPY VASCUTHERM UNIT PURCHASE: 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

ORTHOFIX: 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

PRE-OPERATIVE MEDICAL CLEARANCE INCLUDING LAGS: CBC,CMP PT, UA AND POSSIBLE CHEST X-RAY: 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

INTRAOPERATIVE NEURO-PHYSIOLOGICAL MONITORING: 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

HOME HEALTH CARE, INITIAL VISIT THEN 1-2 SKILLED NURSE VISITS FOR WOUND MONITORING: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES HOME HEALTH SERVICES, 51.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.