

<b>Case Number:</b>	CM14-0169993		
<b>Date Assigned:</b>	10/20/2014	<b>Date of Injury:</b>	10/20/2012
<b>Decision Date:</b>	11/20/2014	<b>UR Denial Date:</b>	09/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/15/2014

### 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 Orthopedic Spine Surgery and is licensed to practice in Texas. 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 injured worker is a 51-year-old female who reported a twisting injury on 10/20/2012. The current diagnoses include sacroiliitis, sacroiliac ligament sprain/strain, lumbar myofascial sprain/strain, hip osteoarthritis, and hip bursitis. Previous conservative treatment is noted to include sacroiliac injections, medications, physical therapy, and acupuncture. The latest sacroiliac joint injection procedure is noted on 06/27/2014. The injured worker was evaluated on 08/14/2014 with complaints of lower back pain and right thigh pain. The current medication regimen includes Lidoderm 5% patch and meloxicam 7.5 mg. Physical examination revealed 80 degrees flexion, 20 degrees extension, bilateral lumbar tenderness, PSIS tenderness, positive Gaenslen's testing on the right, tenderness over the right greater trochanter and distal gluteus, normal motor strength, and positive faber testing on the right. Treatment recommendations included a sacroiliac joint fusion. There was no Request for Authorization form submitted for this review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Associated surgical service: Post-Op Physical Therapy 2 x 6, for the low back:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 10  
23.

**Decision rationale:** California MTUS Guidelines state the initial course of therapy means 1 half of the number of visits specified in the general course of therapy for this specific surgery in the postsurgical physical medicine treatment recommendations. Postsurgical treatment following a fusion includes 24 visits over 10 weeks. The requested surgical procedure has not been authorized at this time. Therefore, the current request is also not medically necessary.