

Case Number:	CM14-0070728		
Date Assigned:	07/14/2014	Date of Injury:	03/30/2009
Decision Date:	08/12/2014	UR Denial Date:	04/16/2014
Priority:	Standard	Application Received:	05/16/2014

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 Anesthesiology, has a subspecialty in Pain Medicine 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 65 year old male who had a work related injury on 03/30/09. The injured worker states that he was rear-ended by a semi-tractor truck while he was at work. He reported the injury to his employer and supervisor. He did not continue to work his shift. He was sent to the hospital the next day and was seen by a general practitioner. He received medication. He attended 16 sessions of physical therapy and 6 sessions of acupuncture therapy and also he received 8 epidural steroid injections. He has had MRI scans and x-rays performed. October of 2012 the injured worker underwent a posteriolateral fusion at L3 to S1 followed by a back brace and postoperative physical therapy for 18 sessions. The injured worker had bilateral SI joint injections on 04/16/13, bilateral L5, S1, and S2 peripheral nerve blocks on 07/23/13, a radiofrequency ablation of the right L5, S1, and S2 branches enervating the SI joints on 08/13/13. CT scan dated 08/20/13 interval surgery with placement of interspinous spacers at L3-4 and L5-S1. Mild to moderate lumbar degenerative changes essentially stable compared to 09/29/11. There was a moderate L4-5 spinal canal stenosis, foraminal stenosis present at several levels as described, most pronounced on the right at L5-S1 where there may be compromise of the exiting right L5 nerve root. He continues to report episodes of low back pain particularly worse in the morning. He has also noted 1 or 2 episodes of pain traveling down the left leg. He has functionally been more active and has been stable on the decreased intake of pain medication. Medications are Norco 10/325mg, Neurontin 300mg, and Naproxen 500mg. the physical examination on 04/02/14 he stands forward flexed at the waist with a mild anterior pelvic tilt. The surgical scar is intact and without drainage. There was mild tenderness to palpation around the right sciatic notch and mild tenderness around the left SI joint. Standing stork test remains mildly positive on the left. Lumbosacral spine range of motion is within functional limits, the motor strength is 5/5 throughout, the sensation is intact, the slump test is

negative bilaterally and the deep tendon reflexes are 1+ and symmetric. The injured worker reported only 25% relief of pain with the SI joint injections. The request is for bilateral SI joint fusion including medical clearance and assistant surgeon, and a 2 day inpatient stay.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral SI Fusion (including medical clearance and Assistant Surgeon): 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 Official Disability Guidelines (ODG) Hip Chapter, Sacroiliac joint fusion.

Decision rationale: The clinical documentation submitted for review as well as current evidence based guidelines do not support the request. The injured worker received 25% relief with the SI joint injection, and 60% relief with the S1 epidural steroid injection. The clinical records submitted for review indicate that the injured worker has functionally been more active and has been stable on the decreased intake of pain medication. And the physical exam on 4/2/14 did not show proactive signs of SI joint involvement; he had mild tenderness to palpation around the right sciatic notch and mild tenderness around the left SI joint. Standing stork test remains mildly positive on the left. I do not believe that the pain generator has been identified. Therefore, medical necessity has not been established. The request for medical clearance and assistant surgeon is predicated on the initial surgical request. As this has not been found to be medically necessary the subsequent request is not necessary.

Inpatient stay 2 days: 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 Official Disability Guidelines (ODG) Low Back Chapter, Hospital length of stay (LOS).

Decision rationale: The request for inpatient stay for two days is predicated on the on the initial surgical request. As this has not been found to be medically necessary the subsequent request is not necessary.