

<b>Case Number:</b>	CM14-0081603		
<b>Date Assigned:</b>	07/18/2014	<b>Date of Injury:</b>	07/27/2010
<b>Decision Date:</b>	08/25/2014	<b>UR Denial Date:</b>	05/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/02/2014

### 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 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 53 year old female who had a work related injury on 07/27/10. There is no documentation of the mechanism of injury. The injured worker has been treated for lumbar disc disease, lumbar radiculopathy and bilateral sacroiliac joint arthropathy. Office visit dated 01/07/14 she was complaining of lumbar spine pain which she rated on a pain scale at 7/10. It was described as numbness, radiating down to the right leg depending on the chair while sitting. She experienced off an on needle like sensation only when lying down. She stated that the pain had decreased. She had bilateral L5-S1 transforaminal epidural steroid injections on 11/22/13 which helped by 50% for the 1st month. She underwent bilateral sacroiliac joint injections on 04/18/14 and felt relief by the 3rd day with 70% relief. On examination, the injured worker has a wide based gait and has difficulty with heel to toe walk. There is diffused mild to moderate tenderness over the lumbar paravertebral muscles. There is tenderness over the bilateral sacroiliac joints, positive Fabre's, sacroiliac joint thrust test, and Yeoman's test bilaterally. Seated straight leg raise is positive at 60 degrees bilaterally and supine straight leg raising is positive at 60 degrees on the right and 50 degrees on the left. Lateral bending is 20 degrees bilaterally and flexion is 60 degrees.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Bilateral Sacroiliac Joint Rhizotomy:** Upheld

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

**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:** The injured worker underwent bilateral sacroiliac joint injections on 04/18/14 and felt relief by the 3rd day with 70% relief, but there was no documentation of the duration. Current guidelines state, not recommended. Small randomized control trial concluded that there was preliminary evidence that S1-S3 lateral branch radiofrequency denervation may provide intermediate-term pain relief and functional benefit in selected patients with suspected sacroiliac joint pain. Larger studies are needed to confirm these results and to determine the optimal candidates and treatment parameters for this poorly understood disorder. The clinical documentation submitted for review does not support the request. The request for bilateral sacroiliac joint rhizotomy is not medically necessary.

**Hot cold contrast system:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines Low Back Procedure.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back chapter, Cold/heat packs.

**Decision rationale:** The request for hot/cold contrast system is not medically necessary. Recommended as an option for acute pain. At-home local applications of cold packs in first few days of acute complaint; thereafter, applications of heat packs or cold packs. As such the request is not medical necessity.