

Case Number:	CM15-0001435		
Date Assigned:	01/12/2015	Date of Injury:	06/17/2013
Decision Date:	03/19/2015	UR Denial Date:	12/05/2014
Priority:	Standard	Application Received:	01/05/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Pennsylvania, Ohio, California
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 female patient who sustained an industrial injury on 06/17/2013. An orthopedic follow up visit dated 11/24/2014 reported current prescribed medications of Calypso, Flector, Mentoderm, Naproxen, Omeprazole and Tramadol. Subjective complaints found continued left sided pain, but she also stated wonderful effectiveness from previous sacroiliac joint injection. She also expressed interest in receiving radiofrequency ablation to right S-1. The physical examination is noted as unchanged. Previous treatments include; 10/13/2014 right transforaminal epidural, 10/21/2014 right L5-S-1 transforaminal epidural, and 11/18/2014 right dorsal ramus nerve block L5 S1 and S2. She is diagnosed with lumbar fact arthropathy, sacroilitis, sacral arthropathy, myofascial pain and greater trochanteric bursitis. On 12/05/2014 utilization Review non-certified a right S 1 radiofrequency ablation, noting ODG sacroiliac radiofrequency is cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Radiofrequency Ablation Right SI: 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 Chapter

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 18th Edition (web), 2013, Treatment in Workers Compensation, Hip, Sacroiliac Joint Radiofrequency Neurotomy.

Decision rationale: The Medical Treatment Utilization Schedule does not specifically discuss radiofrequency ablation to the sacroiliac joint region. Official Disability Guidelines/Treatment in Workers Compensation/Hip does have a section on sacroiliac joint radiofrequency neurotomy. This reference does not recommend radiofrequency neurotomy or radiofrequency ablation in this area, because the anatomy of the sacroiliac joint is not well understood and because there is no consensus agreement on the method of performing such a procedure. The records in this case do not provide an alternate rationale to support this request. Therefore, this request is not medically necessary.