

<b>Case Number:</b>	CM15-0142730		
<b>Date Assigned:</b>	08/03/2015	<b>Date of Injury:</b>	07/31/2013
<b>Decision Date:</b>	09/01/2015	<b>UR Denial Date:</b>	06/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/23/2015

### 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: Illinois, California, Texas  
 Certification(s)/Specialty: Orthopedic Surgery

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This injured worker is a 42-year-old female who sustained an industrial injury on 7/31/13. Injury occurred when she slipped and almost fell down some stairs and caught herself. She underwent anterior posterior segmental instrumentation and fusion at L5/S1 with bilateral laminectomy and facetectomy at L5 on 2/7/14. She had a wound infection requiring two washouts and IV antibiotics on an extended basis, and was diagnosed with MRSA as the underlying infection. The 8/14/14 lumbar spine MRI impression documented a combination of degenerative disc disease, facet arthropathy, and ligamentum flavum redundancy contributing to mild to moderate L3/4 and mild to moderate L4/5 lateral recess narrowing causing effacement of the transiting bilateral L4 and right L5 nerve roots. There was mild to moderate L3/4 and L4/5 neuroforaminal narrowing causing mild deformity to the exiting L3 and L4 nerve roots. There was laterally directed disc and osteophyte disease contacting the exiting bilateral L3 through L5 nerve roots in the extraforaminal zone. The 4/9/15 lumbar spine CT myelogram impression documented post-surgical changes consistent with anterior and posterior fusion at the L4/5 level with no significant central canal narrowing, however there was mild to moderate lateral recess, moderate to severe subarticular, and mild to moderate neuroforaminal narrowing. At L3/4, there was a diffuse disc bulge with ligamentum flavum redundancy and bilateral facet hypertrophy with mild central canal, mild to moderate lateral recess, moderate to severe subarticular, and mild to moderate neuroforaminal narrowing. At L5/S1, there was no significant central canal narrowing but there was mild to moderate neuroforaminal narrowing. In the left neural foramen, the endplate osteophyte formation abutted the exiting left L5 nerve root. The 4/27/15 treating

physician report cited grade 7/10 persistent buttock pain status post fusion. Physical exam documented the incision healing well with no signs of infection, 5/5 lower extremity strength, and intact sensation. Imaging showed mild stenosis at the L4/5 level. The treating physician report reported SI joint injections with varied relief of 4 days to 2 weeks. Surgical options were discussed. The 5/12/15 neurosurgical report cited on-going low back pain radiating into her buttocks and legs following surgery. Pain was primarily in the left buttock extending towards her knee with recent increase in back pain. Recent left sacroiliac (SI) injections had provided at least 60% improvement for nearly 5 to 6 days. She was referred for a second opinion regarding SI joint fusion. Physical exam documented pain with any provocative maneuvers of the left SI joint. Strength, sensation, and motor function were intact. The 4/9/15 CT myelogram was reviewed, noting that her SI joints were not imaged. The various pain generators were discussed. An L3/4 epidural steroid injection was recommended to rule-out the L3/4 level as the cause for her pain. Future consideration of SI joint fusion was noted. Authorization was requested on 6/12/15 for left sacroiliac joint fusion, and pre-op CBC, CMP, PT, and PTT. The 6/22/15 utilization review non-certified the request for left sacroiliac joint fusion and associated pre-operative lab work as there was no indicated that the patient had a posttraumatic injury of the sacroiliac joint or chronic pain lasting years, and sacroiliac joint injections had provided no significant relief which failed to meet guidelines criteria. The 6/30/15 treating physician report appeal letter indicated that the injured worker had 2 SI joint injections with significant pain reduction and she was able to stop of all pain medications for 4 day, followed by return of pain. It was very reasonable to consider an SI joint fusion to try to alleviate her pain.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Left sacroiliac joint fusion:** 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 & Pelvis.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip & Pelvis, Sacroiliac joint fusion.

**Decision rationale:** The California MTUS do not provide recommendations for sacroiliac joint fusion. The Official Disability Guidelines state that SI joint fusion is recommended on a case by case basis as a last line of therapy, including either open or minimally invasive (percutaneous), as treatment for sacroiliac joint infection, tumor, disabling pain due to sacroiliitis due to spondyloarthropathy, sacroiliac pain due to severe traumatic injury, and the procedure may be required for multi-segmental spinal constructs. Guidelines state that SI joint fusion is not recommended for mechanical low back pain, non-specific low back pain, sacroiliac joint disruption (in the absence of major pelvic fracture), degenerative sacroiliitis, SI joint osteoarthritis, or ?SI joint mediated pain, as this procedure is considered investigational for these indications. For recommended indications, criteria include on-going symptoms, corroborating physical findings and imaging, and failure of non-operative treatment. Guideline criteria have not been met. This injured worker presents with persistent left buttock and posterior thigh pain

following L5/S1 fusion. Physical exam findings documented positive SI joint provocative testing. There is no imaging of the SI joints documented. Diagnostic criteria have not been met. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Therefore, this request is not medically necessary.

**Preop: CBC, CMP, PT and PTT:** 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.