

<b>Case Number:</b>	CM15-0196326		
<b>Date Assigned:</b>	10/20/2015	<b>Date of Injury:</b>	02/03/2003
<b>Decision Date:</b>	12/02/2015	<b>UR Denial Date:</b>	09/28/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/06/2015

### 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: New York, Montana,  
 California Certification(s)/Specialty: Neurological  
 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 is a 53 year old male who sustained an industrial injury on 2-3-2003. A review of the medical records indicates that the injured worker is undergoing treatment for post laminectomy syndrome and sacroiliitis. According to the progress report dated 9-23-2015, the injured worker complained of cervical pain along with radicular pain, numbness and tingling in the right arm. He also complained of back stiffness and pain. Objective findings (9-23-2015) revealed tenderness to palpation of the lower lumbar spine with reduced range of motion. Lumbosacral exam revealed positive pelvic thrust, positive Gainslen's maneuver, positive Patrick's maneuver, positive pelvic rock and positive stork test bilaterally. Treatment has included physical therapy, sacroiliac joint injection (with increased pain) and medications (Percocet, Prilosec, Nortriptyline, Topamax and Ibuprofen). The original Utilization Review (UR) (9-28-2015) denied a request for sacroiliac joint fusion and associated services.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Inpatient Stay x 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 since the requested treatment: Sacroiliac joint fusion is not medically necessary and appropriate, then the Requested Treatment: Inpatient Stay 2 days is not medically necessary and appropriate.

**Decision rationale:** Since the requested treatment: Sacroiliac joint fusion is not medically necessary and appropriate, then the Requested Treatment: Inpatient Stay x 2 days is not medically necessary and appropriate.

**Pre-operative EKG:** 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 since the requested treatment: Sacroiliac joint fusion is not medically necessary and appropriate, then the Requested Treatment: Preoperative EKG is not medically necessary and appropriate.

**Decision rationale:** Since the requested treatment: Sacroiliac joint fusion is not medically necessary and appropriate, then the Requested Treatment: Preoperative EKG is not medically necessary and appropriate.

**Pre-operative Lab work:** 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 since the requested treatment: Sacroiliac joint fusion is not medically necessary and appropriate, then the Requested Treatment: Preoperative Lab work is not medically necessary and appropriate.

**Decision rationale:** Since the requested treatment: Sacroiliac joint fusion is not medically necessary and appropriate, then the Requested Treatment: Preoperative Lab work is not medically necessary and appropriate.

**Preoperative medical clearance:** 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 since the requested treatment: Sacroiliac joint fusion is

not medically necessary and appropriate, then the Requested Treatment: Preoperative medical clearance is not medically necessary and appropriate.

**Decision rationale:** Since the requested treatment: Sacroiliac joint fusion is not medically necessary and appropriate, then the Requested Treatment: Preoperative medical clearance is not medically necessary and appropriate.

**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 Since the requested treatment: Sacroiliac joint fusion is not medically necessary and appropriate, then the Requested Treatment: Assistant surgeon is not medically necessary and appropriate.

**Decision rationale:** Since the requested treatment: Sacroiliac joint fusion is not medically necessary and appropriate, then the Requested Treatment: Assistant surgeon is not medically necessary and appropriate.

**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-Treatment in Workers' Comp (ODG-TWC), 20th Edition, 2015, Hip and Pelvis chapter: Sacroiliac joint fusion.

**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 fusion.

**Decision rationale:** The ODG guidelines state the sacroiliac 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." Documentation shows that these are conditions which the patient has. Moreover, he had increased pain instead of decreased pain after the sacroiliac injection. The requested treatment of Sacroiliac joint fusion is not medically necessary and appropriate.