

<b>Case Number:</b>	CM15-0210238		
<b>Date Assigned:</b>	10/29/2015	<b>Date of Injury:</b>	02/02/2004
<b>Decision Date:</b>	12/10/2015	<b>UR Denial Date:</b>	10/01/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/26/2015

### 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 62-year-old male who sustained an industrial injury on 2/2/04. Mechanism of injury was not documented. Past surgical history was positive for spinal cord stimulator implantation in 2006 and removal on 5/5/12. Records indicated that he was status post lumbar spine surgery but the specifics were not documented. Records indicated that the 11/14/13 lumbar spine MRI documented multilevel disc degeneration and facet arthropathy. At L3/4, there was a left lateral disc protrusion causing a mild mass effect on the transiting left L4 nerve root and a right lateral recess disc extrusion causing a mild mass effect on the transiting right L4 nerve root. The 11/14/13 pelvis MRI was reported as a negative study with no findings of sacral insufficiency. He underwent bilateral sacroiliac (SI) joint injections on 12/22/14 with a reported reduction in pain from grade 7/10 to 1/10. He also had been treated with radiofrequency lesioning, facet blocks and epidural steroid injections. The 9/11/15 treating physician report cited worsening low back pain radiating to the groin and legs, worse on the right. Pain was reported grade 7/10 on the right and 0/10 on the left. Left sided pain was reported markedly improved post fusion. Associated symptoms were reported to include paravertebral muscle spasms, radicular right leg pain, numbness in the legs, and weakness of the upper leg. He had some pain relief with rest, anti-inflammatory medications, narcotic pain medications, and lying down. Pain worsened with walking, twisting movements, and prolonged sitting. Lumbar spine exam documented decreased range of motion and hypoesthesia in the L2, L3 and L4 distributions. Medications (Morphine and Norco) were refilled. The diagnosis included low back and sacroiliac pain and herniated disc. Authorization was requested for right SI joint fusion and one

day inpatient stay. The 10/1/15 utilization review non-certified the request for right SI joint fusion and associated inpatient stay as there was no rationale given for a right SI joint fusion, no evidence to indicate that the pain was from sacroiliitis or a traumatic injury, and no evidence of severe osteoarthritis to support the medical necessity of this request.

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

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

**Right 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 (ODG) Hip & Pelvis (updated 09/24/2015), Online Version, Sacroiliac 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 & Pelvis, Sacroiliac joint fusion.

**Decision rationale:** The California MTUS do not provide recommendations for sacroiliac joint fusion. The Official Disability Guidelines state that sacroiliac 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 the following conditions with ongoing symptoms, corroborating physical findings and imaging, and after failure of non-operative treatment: Sacroiliac joint infection; Tumor involving the sacrum; Disabling pain due to sacroiliitis due to spondyloarthropathy; Sacroiliac pain due to severe traumatic injury; In conjunction with multisegmental spinal constructs (i.e., scoliosis or kyphosis surgery). 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. Guideline criteria have not been met. This injured worker presents with right sided low back pain radiating into the groin and radicular right leg pain. Associated symptoms included paravertebral muscle spasms, numbness in the legs, and weakness of the upper leg. There is documentation of positive response to an SI joint injection. However, clinical exam findings did not document SI joint provocative testing or other findings relative to the SI joint. There is no imaging evidence consistent with sacroiliitis, or sacroiliac joint disruption or osteoarthritis. There are no indications of SI joint infection, tumor, or history of severe traumatic injury. There is no rationale provided to support the medical necessity of this request. 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.

**Associated surgical service: Inpatient hospitalization for 1 day:** 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.