

<b>Case Number:</b>	CM15-0052016		
<b>Date Assigned:</b>	03/25/2015	<b>Date of Injury:</b>	05/30/2000
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	02/25/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/19/2015

### 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  
 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:

The injured worker is a 72 year old female who sustained an industrial injury on 5/30/00. The injured worker reported symptoms in the back. The injured worker was diagnosed as having status post left sacroiliac joint fusion, bilateral sacroiliac joint dysfunction, status post thoracolumbar spinal cord stimulator placement, chronic intractable pain, L1-L2 and L2-L3 adjacent segment degeneration with facet arthropathy, L3-L4 stenosis, bilateral lower extremity radiculopathy and status post L3-L4 decompression, laminotomy and osteotomy. Treatments to date have included oral pain medication, steroid injections, facet blocks, spinal cord stimulator, status post back surgery, and oral pain medication. Currently, the injured worker complains of lower back pain with radiation to the buttocks and lower extremities. The plan of care was for surgical intervention, urine drug screen, physical therapy and a follow up appointment at a later date.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Revision fusion left SI joint w/bone grafting, internal fixation Qty: 1.00: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 307.

**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 (updated 10/09/2014).

**Decision rationale:** The ODG guidelines do not recommend fusion of the SI joint. Documentation does not show any failure of the hardware at the SI joint or failure of the prior fusion. The requested treatment: Revision fusion left SI w/bone grafting, internal fixation QTY: 1.00 is not medically necessary.

**Associated Surgical Service: Pre-op medical clearance: 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-TWC), Low Back Chapter, Preoperative testing.

**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.

**Associated Surgical Service: Pre-op CXR: 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-TWC), Low Back Chapter, Preoperative testing.

**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.

**Associated Surgical Service: Inpatient LOS (length of stay) (days) Qty: 1.00: 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), Low Back Chapter, Lumbar Fusion, posterior.

**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.

**Associated Surgical Service: Assistant surgeon Qty: 1.00: 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), Low Back Chapter.

**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.

**Associated Surgical Service: Post-op Physical Therapy (sessions) Qty: 18.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**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.

**Associated Surgical Service: Follow-up visit for pre-op education, consent signing Qty: 1.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 341.

**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.