

Case Number:	CM15-0059280		
Date Assigned:	04/03/2015	Date of Injury:	07/10/2009
Decision Date:	05/13/2015	UR Denial Date:	03/19/2015
Priority:	Standard	Application Received:	03/27/2015

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:

The injured worker is a 52-year-old female who sustained an industrial injury on 7/10/09. Injury occurred when she went to sit in her rolling chair, and it had moved. She fell down, forcefully landing on her buttocks. The 4/19/13 lumbar spine MRI impression documented mild facet arthropathy at L4/5, normal alignment, and no disc protrusion or central canal narrowing. The 3/3/15 treating physician report cited grade 4/10 low back pain with no change in symptoms. The injured worker reported 80% reduction in pain, 50% in medication, and increased walking tolerance following the left sacroiliac (SI) joint injection performed 2/16/15. Physical exam documented difficulty in heel/toe walk secondary to lower back pain, diffuse tenderness over the paravertebral musculature, and moderate facet tenderness over L4 to S1. Piriformis and SI tests were positive bilaterally. Kemp's and Farfan's tests were positive bilaterally. There was moderate loss of lumbar extension with increased pain reported. Neurologic examination was within normal limits. The diagnosis was lumbar facet syndrome, left SI joint arthropathy, and left piriformis syndrome. The treatment plan recommended authorization for a left SI joint rhizotomy, continuation of present medications, and a hot/cold unit for 30 days after the procedure. The 3/19/15 utilization review non-certified the request for left SI joint rhizotomy as guidelines recommended against SI joint radiofrequency rhizotomy. The request for 30-day rental of a hot/cold therapy unit was non-certified as there was no documentation while the injured worker was unable to use guideline-recommended hot/cold packs and required a high-tech unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left sacroiliac joint rhizotomy: 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 and Pelvis Chapter, Sacroiliac joint radiofrequency neurotomy.

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: Sacroiliac joint radiofrequency neurotomy.

Decision rationale: The California MTUS guidelines do not provide recommendations for sacroiliac (SI) joint radiofrequency rhizotomy. The Official Disability Guidelines state that SI joint radiofrequency neurotomy is not recommended. Evidence is limited for this procedure and the use of all sacroiliac radiofrequency techniques has been questioned, in part, due to the fact that the innervation of the sacroiliac joint remains unclear. A recent review of this intervention in a journal sponsored by the American Society of Interventional Pain Physicians found that the evidence was limited for this procedure. Given the absence of guideline support for this procedure, this request is not medically necessary.

Hot/Cold unit, thirty (30) days: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 155.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), Occupational Medical Practice Guidelines, Chapter 12 Low Back Disorders (Revised 2007), Hot and cold therapies, page(s) 160-161.

Decision rationale: The California MTUS are silent regarding hot and cold therapy devices, but recommend at home applications of hot or cold packs. The ACOEM Revised Low Back Disorder Guidelines state that the routine use of high-tech devices for hot or cold therapy is not recommended in the treatment of lower back pain. Guidelines support the use of hot or cold packs for patients with low back complaints. Guideline criteria have not been met. There is no compelling reason submitted to support the medical necessity of a cold therapy unit in the absence of guideline support. Therefore, this request is not medically necessary.