

<b>Case Number:</b>	CM14-0186197		
<b>Date Assigned:</b>	11/14/2014	<b>Date of Injury:</b>	04/29/2011
<b>Decision Date:</b>	12/30/2014	<b>UR Denial Date:</b>	10/27/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/07/2014

### 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. The expert reviewer is Board Certified in Orthopedic Spine Surgery and is licensed to practice in Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 24-year-old male who reported an injury on 04/29/2011. The mechanism of injury was not documented within the clinical notes. The diagnosis included lumbosacral spondylosis without myelopathy. The past treatments included physical therapy, and a right SI joint injection. There was no official diagnostic imaging studies submitted for review. There was no surgical history documented within the clinical notes. The subjective complaints on 08/21/2014 included back pain and groin pain. The physical exam noted that the back was painful to palpation and the lumbosacral junction on the right. The faber's test was positive with both sides causing right sided pain. The Gaenslen's test was positive with right sided pain. There was moderate tenderness to left inguinal groove. The injured worker's medications were noted to include Protonix 40 mg, and Norco 10/325 mg. The treatment plan was to perform a cool wave radiofrequency procedure of the right SI joint. A request was received for cold radiofrequency procedure of the right SI joint. The rationale for the request was to decrease the injured worker's pain. The Request for Authorization form was not submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cooled Radiofrequency procedure of the right SI joint:** 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 (Acute and Chronic)

**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 request for cooled radiofrequency procedure of the right SI joint is not medically necessary. The Official Disability Guidelines state that sacral joint radiofrequency neurotomies are not recommended. As the procedure is not recommended, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.