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| <b>Case Number:</b>   | CM15-0172918 |                              |            |
| <b>Date Assigned:</b> | 09/15/2015   | <b>Date of Injury:</b>       | 07/11/1998 |
| <b>Decision Date:</b> | 10/29/2015   | <b>UR Denial Date:</b>       | 08/25/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 09/02/2015 |

### 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

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 (IW) is a 56 year old male who sustained an industrial injury on 07/11/1998. Records of 08-10-2015 indicate the worker was being treated in pain management for failed back surgery syndrome, lumbar postlaminectomy syndrome, history of five lumbar surgeries, history of previous intrathecal opiate pump (explanted as it was not helpful), probable cluneal nerve injuries secondary to surgery for iliac crest bone harvesting, and possible sacroiliitis. In the Primary Treating Physician's Progress Report (PR-2) of 08-05-2015, a history of multiple back surgeries is reviewed. The injured worker complains of constant pain and an inability to do normal life activities. He is taking methadone 40 mg daily. On the visit prior, the worker was given an unblinded cortisone injection into the Left Sacroiliac joint area without benefit of fluoroscopic assistance according to the documentation followed by good relief of pain for 4 days, but the pain returned. On examination, the worker is noted to have a slight antalgic gait to the left side, recurrent exquisite tenderness over the left sacroiliac joint and constant pain on lumbar flexion. According to the notes, a CAT scan of his sacroiliac joint performed 06-15-2015 showed moderate bilateral sacroiliac joint osteoarthritis with joint space narrowing, vacuum phenomenon, subchondral sclerosis, and mild anterior osteophytes. The treatment plan included Norco for pain, and cortisone injection (08-05-2015) into the left sacroiliac joint. A request is planned to perform a left sided sacroiliac joint fusion for relief of his chronic left sacroiliac joint pain. A request for authorization was submitted for: 1. Left Sacroiliac Joint Fusion. 2. Pre-operative Medical Clearance. 3. Post-Operative Physiotherapy, 16 sessions. 4. Associated Surgical Services: Cortisone injection. 5. Associated Surgical Services: Norco 10/325 mg Qty

60. A utilization review decision 08/25/2015, certified the request for Norco 10/325 mg Qty 60 and non-certified the following: Left Sacroiliac Joint Fusion, Pre-operative Medical Clearance, Post-Operative Physiotherapy, 16 sessions, Associated Surgical Services: Cortisone injection.

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

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

#### **Left 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: Hip & Pelvis (Acute & Chronic) - 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 and Pelvis chapter-Sacroiliac fusion.

**Decision rationale:** A blinded catheter sacroiliac joint block with fluoroscopic assistance is no longer advised in the diagnosis of a symptomatic sacroiliac joint. The patient has not undergone such a diagnostic block. That said, the fact the patient had relief for four days confounds the duration of local anesthetic usually used for such a block. This patient with a history of seven failed lumbar operations on chronic narcotics for over ten years does not have a high likelihood of a good outcome from the proposed procedure. In order to prove the diagnosis all other pain generators should also be ruled out. This has not been done in this patient. The ODG guidelines note that a sacroiliac fusion is a last resort intervention for sacroiliac joint infection, tumor involving the sacrum, disabling pain due to sacroiliitis due to spondyloarthropathy, sacroiliac pain due to severe traumatic injury and surgery for scoliosis or kyphosis surgery. The patient has none of these indications. They note literature notes the true role of SI joint fusion is murky. The requested treatment: left sacroiliac joint fusion is not medically necessary and appropriate.

#### **Pre-operative 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 cite any medical evidence for its decision.

**Decision rationale:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

#### **Post-operative Physiotherapy, 16 sessions: 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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

**Associated Surgical Services: Cortisone injection:** 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:** As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.