

Case Number:	CM15-0078244		
Date Assigned:	04/29/2015	Date of Injury:	03/09/2001
Decision Date:	05/28/2015	UR Denial Date:	04/14/2015
Priority:	Standard	Application Received:	04/24/2015

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 56-year-old female who sustained an industrial injury on 3/9/01. The mechanism of injury was not documented. The 8/9/13 lumbar spine MRI impression documented a 3 mm left paracentral disc extrusion extending superiorly behind the L2 vertebra on the left resulting in abutment of the descending left L3 nerve root with a mild degree of central canal narrowing. The 3/17/15 treating physician report cited grade 7/10 burning and throbbing lower back pain with very limited lumbar range of motion. She underwent bilateral sacroiliac (SI) joint injections on 2/16/15 with 85% relief for 3 weeks with decreased burning and throbbing in the lumbar spine and more mobility, and was able to stop all medications. Physical exam documented wide-based gait and ability to perform heel/toe walk with slight low back pain. Lumbar spine exam documented increased lordosis, mild tightness and tenderness with lumbar paraspinal muscle guarding, and mild L4-S1 facet tenderness. There was positive piriformis and SI joint tenderness. There were positive FAIR, Fabere's, sacroiliac thrust and Yeoman's tests. Straight leg raise produced back pain bilaterally. Lumbar range of motion was mildly limited. Lower extremity neurologic exam was within normal limits. The diagnosis was lumbar disc disease, facet syndrome, and bilateral sacroiliac joint arthropathy. The treatment plan requested authorization for bilateral SI joint rhizotomy to be done on separate days. The 4/14/15 utilization review non-certified the request for bilateral SI joint rhizotomy and associated hot/cold unit as there was no guideline support for SI joint rhizotomy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral sacroiliac joint rhizotomy to be done on separate days: 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.

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 joint radiofrequency rhizotomy. The Official Disability Guidelines state that sacroiliac 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 enervation 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.

Associated surgical service: Hot/Cold unit rental following the rhizotomy procedure: 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 Procedure.

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(MTUS), 2009.

Decision rationale: The California MTUS are silent regarding hot/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 hot/cold therapy unit in the absence of guideline support. Additionally, the associated rhizotomy procedure request is not supported. Therefore, this request is not medically necessary.