

<b>Case Number:</b>	CM15-0079556		
<b>Date Assigned:</b>	04/30/2015	<b>Date of Injury:</b>	10/05/2004
<b>Decision Date:</b>	06/01/2015	<b>UR Denial Date:</b>	04/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	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: 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 49 year old female, who sustained an industrial injury on 10/05/2004. She has reported injury to the low back. The diagnoses have included right sacroiliac joint dysfunction, confirmed with diagnostic sacroiliac joint block; lumbar/lumbosacral disc degeneration; post-laminectomy syndrome-lumbar; and status post anterior/posterior interbody fusion/instrumentation L4/L5/S1. Treatment to date has included medications, diagnostics, radiofrequency ablation bilaterally at sacroiliac, physical therapy, and surgical intervention. Medications have included Anaprox, Xanax, Zanaflex, and Butrans Patch. A progress note from the treating physician, dated 03/30/2015, documented a follow-up visit with the injured worker. Currently, the injured worker complains of neck pain radiating into the mid-scapular region, with numbness in the forearms to the hands and thumbs; and low back pain radiating into the buttock and right posterior thigh, with numbness in the shins bilaterally. Objective findings included tenderness over the sacroiliac joints, bilaterally; markedly positive thigh thrust bilaterally, right greater than left; and markedly positive pelvic compression test bilaterally, right greater than left. The treatment plan has included the request for right sacroiliac (SI) joint fusion; inpatient length of stay, 1 day; preoperative medical clearance-Complete Blood Count (CBC), Chem 7, Prothrombin Time (PT), Partial Thromoplastin Time (PTT), and Urinalysis (UA); postoperative physical therapy 3 times a week for 6 weeks; associated surgical service: pneumatic intermittent compression device, 30 day rental; and urine toxicology screen on follow-up visits, #3.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right sacroiliac (SI) 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 (ODG), Hip & Pelvis Chapter - Indications for SI Joint 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 joint fusion.

**Decision rationale:** The ODG guidelines do not recommend sacroiliac joint fusion except as a last resort for chronic or severe sacroiliac joint pain. The documentation does not provide evidence that all conservative treatments have been exhausted. Documentation provides no objective evidence the pain generator in this patient is in the sacroiliac joint. The requested Treatment: Right sacroiliac (SI) joint fusion is NOT Medically necessary and appropriate.

**Associated surgical services: Inpatient length of stay, 1 day: 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:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated surgical service: Pneumatic intermittent compression device, 30 day rental: 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:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Postoperative physical therapy 3 times a week for 6 weeks: 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:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Preoperative medical clearance - Complete Blood Count (CBC), Chem 7, Prothrombin Time (PT), Partial Thromboplastin Time (PTT) and Urinalysis (UA): 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:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Urine toxicology screen on follow-up visits, #3: 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:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.