

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

P.O. Box 138009

Sacramento, CA 95813-8009

(855) 865-8873 Fax: (916) 605-4270



**Notice of Independent Medical Review Determination**

Dated: 11/27/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	8/1/2013
Date of Injury:	8/23/2008
IMR Application Received:	8/12/2013
MAXIMUS Case Number:	CM13-0009778

- 1) MAXIMUS Federal Services, Inc. has determined the request for **left side sacroiliac joint radiofrequency ablation is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/12/2013 disputing the Utilization Review Denial dated 8/1/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/17/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the request for **left side sacroiliac joint radiofrequency ablation** is not **medically necessary and appropriate**.

### **Medical Qualifications of the Expert Reviewer:**

The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Occupational Medicine, and is licensed to practice in California. 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 treatments and/or services at issue.

### **Expert Reviewer Case Summary:**

All medical, insurance, and administrative records provided were reviewed.

The applicant is a represented healthcare industry employee who has filed a claim for chronic shoulder, neck, and low back pain reportedly associated with an industrial injury of August 23, 2008. Thus far, the applicant has been treated with the following: Analgesic medications; transfer of care to and from various providers in various specialties; attorney representation; prior epidural steroid injection therapy; prior SI joint injection therapy in May 2013; an MRI of the lumbar spine of February 5, 2013, notable for multilevel low-grade degenerative changes and disc protrusions of uncertain clinical significance; normal electrodiagnostic testing of bilateral upper and bilateral lower extremities dated February 5, 2013; extensive periods of time off of work; shoulder corticosteroid injections in unspecified amounts; and prior anterior cervical discectomy and fusion at C5 through C7.

In a utilization review report of August 1, 2013, the claims administrator denied request for a left SI (sacroiliac) joint injection. The applicant's attorney subsequently appealed, on August 7, 2013. An earlier note of July 10, 2013 is notable for comments that the applicant reports persistent neck and severe left sacroiliac joint pain. There is associated lumbar paraspinal tenderness and SI joint tenderness. The applicant is asked to remain off of work, on total temporary disability, and pursue a left-sided SI joint radiofrequency ablation procedure.

### **Documents Reviewed for Determination:**

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application of Independent Medical Review
- Utilization Review Determination
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

### **1) Regarding the request for left side sacroiliac joint radiofrequency ablation :**

#### Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Original Disability Guidelines, Hip and Pelvic Chapter, Sacroiliac Joint Radiofrequency Neurotomy, which is not part of the MTUS.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM) Guidelines, 3<sup>rd</sup> Edition, Low Back Chapter, Sacroiliac Joint Injections, which is not Part of the MTUS.

#### Rationale for the Decision:

As noted in the Third Edition ACOEM Guidelines, sacroiliac joint injections are not recommended except in those individuals with a rheumatologically proven spondyloarthropathy. In this case, however, the employee does not have the rheumatologically proven sacroiliac joint spondyloarthropathy for which SI joint injections would be indicated. Rather, the employee has nonspecific low back pain for which SI joint injections are not, per ACOEM, recommended. The fact that multiple other injection procedures, including epidural injections, are being pursued, suggest a lack of diagnostic clarity. It is further noted that the employee appears to have had prior SI joint injection therapy in the past and has failed to derive any lasting benefit or functional improvement through prior usage of same. The fact that the employee remains off of work, on total temporary disability, imply the lack of functional improvement as defined in MTUS 9792.20(f). **The request for left side sacroiliac joint radiofrequency ablation is not medically necessary or appropriate.**

**Effect of the Decision:**

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely,

Paul Manchester, MD, MPH  
Medical Director

cc: Department of Industrial Relations  
Division of Workers' Compensation  
1515 Clay Street, 18<sup>th</sup> Floor  
Oakland, CA 94612

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Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.