

MEDICAL REVIEW OF TEXAS

[IRO #5259]

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DATE OF REVIEW: **APRIL 30, 2007**

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

S1 Joint Fixation

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

MD, Board Certified in Orthopaedic Surgery

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Spine Center: Office notes dated 9/21/06 – 3/9/07; MD Operative report dated 8/22/06, 5/8/06, 2/6/06, 8/29/05; Denial dated 3/16/07; Appeal Denial dated 3/30/07
- Indemnity notes describing patient history dated 3/14/07 – 4/4/07; dated 6/28/06

PATIENT CLINICAL HISTORY [SUMMARY]:

Patient has a long history of lower back problems. Initially he was injured while working in due to a fall. He had laparoscopic spine surgery done at with some improvement. He apparently returned to work after that date and has recurrence of the pain. He subsequently lived in and continued to work

for. He had increasing back symptoms in 2005 and saw Dr.. He was treated with medications and injections and subsequently had an L3 to S1 arthrodesis.

In June 2006 he had repeat MRI scan showing extensive post surgical changes at L4-5 and L5-S1 with bilateral laminectomies from L3 to L5 with some evidence of foraminal narrowing at L4-5 and L5-S1. Dr. subsequently requested hardware removal and this was accomplished on 8/23/06. He subsequently had an epidural steroid injection done in January 2007. He continued to complain of pain over his S1 joints. He has undergone several S1 joint injections with apparent improvement in his pain. Dr. has apparently requested authorization for sacroiliac joint fusions. The request for these procedures has been reviewed by Drs. both of whom recommended non-authorization due to the fact that this is an uncommon orthopaedic procedure and is relatively contraindicated in the face of a lumbar fusion. There is no evidence based medicine to suggest that fusion would alleviate his pain symptoms.

Review of records from Dr. indicates that he had sacroiliac joint injections on 5/8/06 and 2/6/06. Dr. also recommended in 11/2006 that the patient be referred for pain management. On 3/9/07, Dr. noted that the S1 joint injection had helped him but they were beginning to wear off. The patient apparently wanted to proceed with surgical treatment and Dr. suggested trying S1 joint fixation. His rationale was that the patient had improvement with the injections so he suspected he would get improvement with fixation. The examination showed a positive Gaenslen's test and negative Fabere test. His impression was status post S1 joint injection and sacroiliac joint dysfunction. Notes were not made regarding any radiographic findings or degenerative changes in the sacroiliac joints.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

BASED UPON REVIEW OF THESE RECORDS, NON AUTHORIZATION FOR SACROILIAC JOINT FIXATION IS INDICATED. THERE IS NO EVIDENCE BASED MEDICINE THAT SUGGESTS SACROILIAC JOINT FIXATION WOULD RESULT IN RELIEF OF VAGUE LOWER POSTERIOR PELVIC PAIN IN A PATIENT WITH MULTIPLY OPERATED BACK AND SIGNIFICANT LEVEL OF LUMBAR FUSION ABOVE THE S1 JOINTS. ANATOMICALLY, THE S1 JOINTS HAVE VERY LITTLE MOTION AND ARE USUALLY RESISTANT TO ARTHRITIC DEGENERATION EXCEPT IN CASES OF SEVERE TRAUMA. IN THOSE CASES RADIOGRAPHS OFTEN DEMONSTRATE IRREGULARITY, SCLEROSIS AND OBVIOUS DEGENERATIVE CHANGES IN THE JOINTS, WHICH CAN ALSO BE WELL SEEN ON CT SCAN. THIS PATIENT DEMONSTRATES NONE OF THESE FINDINGS PER THE MEDICAL RECORDS. THE RELIABILITY OF THE FACT THAT HE APPEARED TO HAVE SOME RELIEF FROM THE S1 INJECTIONS IS VERY QUESTIONABLE IN VIEW OF THE COMPLEX INNERVATION OF THE SACROILIAC JOINTS MAKING IT DIFFICULT TO PREDICT THAT AN INJECTION, WHICH CAUSED

SOME PAIN RELIEF, WOULD LEAD TO THE CONCLUSION THAT FUSION OR FIXATION OF THE JOINT WOULD RELIEVE THE SYMPTOMS.

ADDITIONALLY, SIMPLE FIXATION OF THE JOINT WOULD BE INAPPROPRIATE. IF SURGERY WERE TO BE PERFORMED THE JOINT NEEDS TO BE DENUDED OF ARTICULAR CARTILAGE AND PACKED WITH BONE GRAFT AS WELL AS FIXED TO ACHIEVE SOLID ARTHRODESIS. SIMPLE FIXATION WOULD PROBABLY RESULT IN PAINFUL HARDWARE DUE TO CONTINUED MOTION IN THE JOINT THUS NECESSITATING ANOTHER SURGERY FOR HARDWARE REMOVAL AND WOULD PROBABLY DAMAGE OR IRRITATE THE JOINT EVEN FURTHER IF IT WAS NOT ARTHRODESED AT THE SAME TIME.

THE ODG AND ACOM GUIDELINES DO NOT HAVE ANY INFORMATION APPLICABLE TO FIXATION OF THE S1 JOINT.

AS NOTED PREVIOUSLY BY DR. DISCUSS ARTHRODESIS OF THE SACROILIAC JOINT FOR UNSTABLE FRACTURES. ADDITIONALLY, THE *ORTHOPAEDIC KNOWLEDGE UPDATES* INDICATE THAT OCCASIONALLY SACROILIAC JOINT FIXATION AND/OR FUSION IS APPROPRIATE FOR POSTERIOR PELVIC FRACTURE DISLOCATION OF THE JOINT.

CAMPBELL'S OPERATIVE ORTHOPAEDIC STATES "ARTHRODESIS OF THE SACROILIAC JOINT IS RARELY INDICATED. IT IS PROBABLY THE TREATMENT CHOICE FOR TUBERCULOSIS INVOLVING THE JOINT, BUT THIS IS RARE IN THIS COUNTRY. ARTHRODESIS IS ALSO OCCASIONALLY INDICATED AFTER AN OLD FRACTURE DISLOCATION OF THE SACROILIAC JOINT WITH PAIN PERSISTING FOR 18 TO 24 MONTHS." THE CLAIMANT DEMONSTRATES NONE OF THESE FINDINGS AND BASED UPON THE MEDICAL RECORDS AND THE LACK OF MEDICAL EVIDENCE TO SUPPORT FIXATION OF THE S1 JOINT, NON AUTHORIZATION IS UPHELD AS THERE IS NO SOUND EVIDENCE BASED SUPPORT FOR FIXATION OF THE S1 JOINT IN THIS SCENARIO.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**

- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE
 - ORTHOPAEDIC KNOWLEDGE UPDATES
 - CAMPBELL'S OPERATIVE ORTHOPAEDIC
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)