

IRO Express Inc.
An Independent Review Organization

Phone Number:
(682) 238-4976

2131 N Collins PMB 433409
Arlington, TX 76011
Email: iroexpress@irosolutions.com

Fax Number:
(817) 385-9611

Notice of Independent Review Decision

Case Number:

Date of Notice: 07/09/2015

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Orthopedic Surgery

Description of the service or services in dispute:

Fusion of sacroiliac joint (left SI fusion)

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)

Patient Clinical History (Summary) The patient is a female who was injured on xx/xx/xx and has been followed for chronic pain syndrome lumbosacral radiculitis and post-laminectomy syndrome of lumbar region. The patient is noted to have had a prior lumbar spine fusion at L4-5 and L5-S1. The patient had also been followed for continuing complaints of left sided sacroiliac joint pain. The patient is noted to have been recommended for a spinal cord stimulator in the past; however, this was not approved. CT studies of the pelvis completed on 04/14/15 noted the prior fusion at L4-5 and at L5-S1. Some bony depth defects were noted in the posterior aspect of the left iliac bone near the sacroiliac joint most likely due to prior harvesting for the lumbar fusion. Otherwise the sacroiliac joints appeared normal. From the records the patient's last sacroiliac joint injection was documented in 2013. The patient had bone density studies completed on 04/16/15 which found normal bone density. It is noted the patient had been recommended for sacroiliac joint rhizotomy; however, this was not recommended as medically necessary in the past. The 05/04/15 clinical record from [redacted] recommended that the patient have further CT scans to assess the left sacroiliac joint. There was a follow up report from [redacted] on 06/08/15 which reported subarticular sclerosis of the sacroiliac joints with air vacuum phenomena. The patient was felt to have osteophytes bilaterally at the sacroiliac joints more significant to the left side. The proposed left sided sacroiliac joint fusion was denied by utilization review as there had been no documentation regarding recent injections. CT studies found normal sacroiliac joints with no evidence of significant sclerosis. There was no indication of osteoarthritis. Due to the limited evidence in the clinical literature supporting sacroiliac joint fusion for addressing chronic sacroiliac joint pain the procedure was not recommended.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The patient has been followed for continuing chronic low back pain complaints as well as post-laminectomy syndrome stemming from a prior L4-5 and L5-S1 lumbar spine fusion. The most recent clinical assessments of this patient did not include any specific findings regarding sacroiliac joint dysfunction. The patient's last documented injection in the clinical record was from 2013. It is unclear if any recent injections had been attempted for the left sacroiliac joint or what the response has been to the injection. Given the lack of any clear efficacy from sacroiliac joint fusion procedures in the current clinical literature, and as imaging found relatively maintained sacroiliac joints with no significant pathology, it is this reviewer's opinion that medical necessity for the proposed left sacroiliac joint fusion is not established at this time. The requesting physician

was still recommending updated CT studies of the sacroiliac joint. There was also previous consideration for sacroiliac for a spinal cord stimulator. In this case it is unclear whether the patient has reasonably failed all other lower levels of care before considering surgical intervention as requested. Therefore the prior denials remain upheld.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ACOEM-America College of Occupational and Environmental Medicine um
- knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- DWC-Division of Workers Compensation Policies and Guidelines
- European Guidelines for Management of Chronic Low Back Pain
- Interqual Criteria
- Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical standards Mercy Center Consensus Conference Guidelines
- Milliman Care Guidelines
- ODG-Official Disability Guidelines and Treatment
- Guidelines Pressley Reed, the Medical Disability Advisor
- Texas Guidelines for Chiropractic Quality Assurance and Practice
- Parameters Texas TACADA Guidelines
- TMF Screening Criteria Manual
- Peer Reviewed Nationally Accepted Médical Literature (Provide a description)
- Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)