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January 26, 2016

IRO CASE

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left SI joint fusion.

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

Diplomate American Board of Orthopaedic Surgery
Fellowship Trained in Spine Surgery

REVIEW OUTCOME:

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

Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

Official Disability Guidelines have been utilized for the denials

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained a work-related injury on XX/XX/XX. At that time, the patient was XX. He swerved to miss another vehicle and while doing so flipped and was ejected from the vehicle. He was life flighted to the hospital.

On XX/XX/XX, electrodiagnostic study was performed because of the patient's low back pain radiating down the left leg. The patient also reported numbness/tingling in the left leg. The study showed evidence of chronic left L5 lumbar radiculopathy, evidence of left tibial motor mononeuropathy of uncertain etiology, clinical report of back pain on the left, and clinical report of extremity paresthesias on the left.

On XX/XX/XX, magnetic resonance imaging (MRI) of the lumbar spine with and without contrast was performed. The study showed at the L4-L5 level there was a circumferential disc bulge measuring 3 mm producing effacement of the thecal sac and mild bilateral neural foramen stenosis. Findings had not changed when compared to the prior study. At L5-S1 level, there was disc desiccation severe disc space narrowing type II Modic endplate changes, circumferential disc bulge measuring 4 mm, and a broad-based left foraminal/far lateral disc protrusion (herniation) measuring 8 mm producing mild central canal stenosis, severe stenosis of the left lateral recess impinging the left S1 nerve root, mild stenosis of the right lateral recess, moderate right neural foramen stenosis touching the exiting right L5 nerve root and severe left neural foramen stenosis impinging the exiting left L5 nerve root. Findings had worsened at this level when compared to the prior study. There was also enhancement of the laminectomy defects at this level with enhancement along the left side of the thecal sac and adjacent to the left S1 nerve root.

On XX/XX/XX, the patient followed up. The patient reported a history of lumbar pain 7/10. The patient had a psychiatric evaluation and was cleared for spinal fusion. The patient also reported cervical pain 4/10, and right shoulder pain 5/10. Current medications were listed as zolpidem, cyclobenzaprine, tramadol and Lorcet. Past medical history was notable for hypertension. Past surgical history was notable for right shoulder arthroscopy, right hip replacement, laminectomy, spinal fusion and cervical fusion. On examination, XX noted tenderness in the paraspinal lumbar region. There was tenderness over the bilateral greater trochanter, bilateral SI joints, and bilateral buttocks. The patient had moderate muscle spasm with decreased muscle tone. The range of motion (ROM) showed limited rotation with moderate restriction, limited lateral flexion with moderate restriction. Muscle strength was 3/5 quadriceps bilaterally, 3/5 hip abduction bilaterally, 2/5 hip adduction bilaterally, 2/5 knee extensor bilaterally, 2/5 knee flexors bilaterally. Achilles reflex was 1/4 in the right and 0/4 in the left side. Sensory testing showed decreased sensation over L5 and S1 bilaterally. The straight leg raising (SLR) testing showed leg pain to foot bilaterally. XX diagnosed lumbar disc displacement. XX noted the patient continued to remain symptomatic. He had relief in his lower extremities following his second lumbar laminectomy. He continued to experience a component of axial mechanical pain and some lower extremity radiculitis. The patient had been through postop PT, activity modification, lumbar ESI and oral NSAIDs. XX recommended discectomy and fusion.

On XX/XX/XX, XX performed lumbar laminectomy with posterior and posterolateral decompression at L5-S1 to decompress the exiting L5 nerve roots on the left at L5-S1, posterolateral fusion L5-S1, posterior segmental instrumentation L5 and S1. The pre and postoperative diagnosis was herniated nucleus pulposus (HNP) L5-S1.

On XX/XX/XX, the patient was discharged from the hospital with instructions to follow up approximately a week after surgery.

On XX/XX/XX, XX obtained lumbar radiographs that showed decreased lumbar lordosis, fusion from L5 to S1. Hardware was in good position and alignment.

A physical therapy progress note indicated that the patient was seen for four visits. The aquatic therapy was helping reducing the pain level. Eight more visits were requested.

On XX/XX/XX, the patient reported back pain 6/10 with discomfort with various movements, soreness,

and stiffness. The patient reported relief from surgery as well as physical therapy. The patient reported neck pain 8/10 with discomfort with side-to-side movements, soreness, and stiffness. The patient started to experience increased upper extremity symptoms including numbness, tingling and weakness. The patient underwent anterior cervical discectomy and fusion a long time ago. On examination of the patient's lumbar spine, there was mild tenderness upon palpation with moderate ROM with flexion and extension. The patient had mild pain with right and left lateral bending. Straight leg raise elicited some mild leg and back pain on the left, negative on the right. The patient had some mild paresthesias along his left L5 and S1 distribution. His reflexes were 2+ in his patellae and 1+ in his Achilles. On examination of the cervical spine, there was tenderness on his right and left posterior cervical region with decreased ROM with flexion and extension and pain with right and left lateral bending. The patient had positive axial compression test and a positive Spurling sign reproducing symptoms in his left upper extremity. His motor strength was weakened in wrist flexion and wrist extension. He had some paresthesias in his forearms bilaterally, left greater than right. The reflexes were blunted bilaterally and barely elicitable. Cervical radiographs revealed fusion at C5-C6 level. There was decreased disc space at C5-C6 and C7-T1 areas. XX diagnosed status post fusion of the lumbar spine and increased neurological symptoms of the upper extremities status post ACDF. XX ordered MRI of the cervical spine.

PT progress note was documented.

XX reviewed the MRI cervical spine and noted disc protrusion herniation at C4-C5 producing mild central stenosis and moderate stenosis in the bilateral recesses touching the bilateral L5 nerve roots. There was also moderate central canal stenosis and severe stenosis bilaterally at the C7-T1 levels. XX now diagnosed status post fusion of the cervical spine, cord contact stenosis with upper extremity radiculopathy with disc herniation, status post lumbar fusion doing well postoperatively. XX recommended cervical epidural steroid injection (ESI). Aquatic therapy for lumbar spine was continued.

On XX/XX/XX, the patient reported neck pain rated 7/10 with upper extremity numbness, tingling, and weakness. He also complained of low back pain rated 4/10 with occasional lower extremity weakness, numbness and tingling. XX recommended injection at the C6-C7 level.

On XX/XX/XX, the patient reported neck pain 6/10 with radiation to bilateral shoulders. He continued to experience upper extremity numbness, tingling, and weakness. On examination of the cervical spine, there was tenderness on the right and left posterior cervical region with limited ROM with extension and pain with right and left lateral bending. There was positive axial compression test. He continued to experience upper extremity numbness, tingling and weakness in the C5, C6 and C7 distribution. The patient's reflexes were blunted and barely elicitable. On examination of the lumbar spine, there was tenderness on the left SI joint region. The patient had a positive FABER test, positive Fortin finger test, and positive flamingo test. XX diagnosed status post fusion, C6-C7 with upper extremity radiculopathy, status post lumbar fusion and left SI joint pain. XX recommended SI fusion, cervical ESI, and prescribed lumbar support.

XX performed left SI joint injection. The pre and postoperative diagnosis was left SI joint strain.

A physical therapy evaluation was completed.

Physical Therapy Discharge Summary was documented on XX/XX/XX. Treatment programs included aquatic PT protocols, therapeutic massage, and whirlpool.

On XX/XX/XX, the patient followed up. He reported approximately 80% relief of his back pain, and he was very happy with the results of the injection right up until late January. Currently, the patient's pain level was 7/10. He complained of constant soreness on the left side of his back radiating to the back part of his left thigh. The patient stated his right shoulder had not been painful since the rotator cuff repair in XX/XXXX. The patient still complained of 7/10 neck pain. He had a cervical fusion performed XXXX. On physical examination, the patient had positive FABER on the left. He had positive distraction, reproducing pain on the left sacroiliac joint. He had a positive finger test on the left sacroiliac joint as well as a positive posterior shear on the left, but negative on the right. XX diagnosed left SI pain status post fusion L5-S1 and HNP cervical spine status post ACDF. XX recommended repeat SI injection and ordered some PT for patient's back.

On XX/XX/XX, XX prescribed Mobic and Ultram and referred the patient to a medication management doctor as the patient was recently discharged.

On XX/XX/XX, XX performed left sacroiliac (SI) joint injection under fluoroscopy. The pre and postoperative diagnosis was left SI joint strain.

XX evaluated the patient on XX/XX/XX. It was noted the patient had C6-C7 fusion in XX and three back surgeries. He had L5-S1 discectomy and fusion in XX. He recently had a trigger point injection with minimal relief. The patient reported the back pain started in the lower back shooting down his legs all the way to his feet involving the big toe. The associated symptoms included numbness, tingling and weakness. The patient had tried exercise, PT, heat, massage, TENS, ESI in the past with minimal relief. The patient reported neck pain shooting down the arms all the way to his hands involving all the fingers. The associated symptoms included numbness, tingling, and weakness. The pain score was 8/10. The patient has had Norco 10/325 mg with good relief in conjunction with heating pads and TENS unit. XX reviewed the diagnostic studies to include MRI lumbar spine from XX/XX/XX. Discogram from XX/XX/XX, showed L4-L5 normal control level, L5-S1 abnormal disc with positive concordant pain and severe fissuring, L3-L4 due to normal control level at L4-5. MRI cervical spine dated XX/XX/XX, showed abnormal straightening of the normal cervical spine curvature suggesting muscle spasm. At C3-C4 level, there was broad-based central disc protrusion (herniation) measuring 3 mm producing mild central canal stenosis and mild stenosis of the bilateral lateral recesses. At the C4-C5 level, there was broad-based central disc protrusion (herniation) measuring 4 mm producing moderate central canal stenosis and moderate stenosis of the bilateral lateral recesses touching the bilateral C5 nerve root. At the C5-C6 level, there was a central disc protrusion (herniation) measuring 2 mm producing effacement of the thecal sac. Complete fusion of the C6 and C7 vertebral bodies. At the C7-T1 level, there were type 1 Modic endplate changes and a circumferential disc bulge measuring 4.5 mm producing moderate central canal stenosis, severe stenosis of the bilateral lateral recesses and severe bilateral neural foramen stenosis impinging the bilateral C8 nerve root. At the T1-T2 level, there was a circumferential disc bulge measuring 4mm producing mild central canal stenosis, moderate stenosis of the bilateral lateral recesses and severe bilateral neural foramen stenosis impinging the exiting bilateral T1 nerve root. Examination of the neck showed moderate decreased cervical spine ROM. Lumbar exam documented pain. Lumbar flexion was 30, extension 5, right bending 15, left bending 15, bilateral rotation 45 degrees. Sciatic notch tenderness was present bilaterally. Sitting SLR was positive on the right 30 degrees, left 10 degrees. Toe walking and heel walking was abnormal

bilaterally. Patrick's test was positive bilaterally. XX diagnosed lumbago and cervicgia and prescribed Norco 10/325, gabapentin 100 mg. The patient was advised work restrictions.

The patient had monthly follow up visits for medication management. XX noted the patient was stable on current medication regimen. Refills of gabapentin and Norco were provided.

On XX/XX/XX, the patient followed up. The patient stated the injection on XX/XX/XX, decreased the pain to 0/10. In addition, arthrogram confirmed injection into the left SI joint. The patient's pain had returned. He had pain with weightbearing in his left leg and he also had significant pain when he tried to get up from sitting in a chair. On examination, the patient's Fortin finger test was positive on the left. FABER test was positive on the left. Distraction and posterior shear were positive on the left. XX diagnosed left SI joint adjacent level disease and recommended left SI joint fusion. The patient had exhausted nonoperative treatment and XX felt that the patient no longer qualified for SI joint injections. The patient had several courses of PT in the past year. He had been on oral NSAIDs and had classic presentation for persistent SI pain.

On XX/XX/XX performed the initial review and denied the request for inpatient left SI joint fusion with one day length of stay with the following rationale: *"The patient is a male who sustained an injury on XX/XX/XX when he was involved in a motor vehicle rollover accident. He was diagnosed with left SI joint adjacent level disease, left sacroiliac pain and status post fusion at L5-S1. A request was made for inpatient left sacroiliac joint fusion with 1 day length of hospital stay. He underwent L5-S1 anterior lumbar interbody fusion. He was previously treated with medication, PT, and left sacroiliac injection. As per the follow-up visit, the patient presented for first post-injection follow-up and stated that he had approximately 80 percent relief of his back pain. He complained of soreness on the left side of his back radiating to the back part of his left thigh rated at 7/10. Examination revealed a positive FABER on the left. He had positive distraction, reproducing pain on the left SI joint. He also had a positive finger test and posterior shear on the left. He had a well-healed lumbar incision. The provider noted excellent relief after a left SI injection that lasted XX months. He had a left sacroiliac joint injection on XX/XX/XX. He stated that he was virtually pain-free for approximately three weeks. The most recent medical report dated XX/XX/XX stated that the patient has left sided low back pain. The patient stated that the sacroiliac injections decreased his pain significantly and for a long time. Unfortunately, over the ensuing weeks, the patient's pain again returned. The patient has been having the sacroiliac related pain for over a year. He has pain with weightbearing in his left leg, and he also has significant pain when he tries to get up from sitting in a chair. On exam, the patient's Fortin finger test was positive on the left, negative on the right. FABER'S test was positive on the left, negative on the right. Distraction and posterior shear tests were positive on the left and negative on the right. Distally, his motor strength and sensation were intact. It was noted that the patient has had good temporary relief of both of his SI joint injections. However, he has exhausted nonoperative treatment, as he no longer qualifies for SI joint injections. He had already had several courses of physical therapy in the past year. He has been on oral nonsteroidal anti-inflammatories, and he has classic presentation for SI pain that has persisted for over a year. Although the patient has sacroiliitis, exhaustion and failure of conservative care with recent Physical Therapy was not documented. Also, updated imaging studies documenting sacroiliac joint spondyloarthropathy were not submitted for review. As such, the medical necessity of this request has not been substantiated. Therefore, the request for inpatient Left SI Joint Fusion and 1 day LOS is non-certified."*

On XX/XX/XX, the patient followed up. The patient continued to complain of axial low back pain with

stiffness, tightness and limited mobility. The neck pain was associated with tightness and stiffness. The reported pain level was 4/10. XX continued to prescribe Neurontin 100 mg and Norco 10/325 mg.

In a note XX stated that XX opinions were conflicting with the ODG. XX stated that “the ODG states that sacroiliac fusion is recommended in conjunction with spinal fusions. The ODG states that the procedure is recommended for ongoing symptoms with corroborating physical findings and imaging after failure of nonoperative treatment. NO further nonoperative treatment would be determined as medically necessary under the ODG. The ODG recommends 1-2 visits of physical therapy over 1 week for Arthropathy in the hip & pelvis section. This patient had much more physical therapy than those recommendations. No additional physical therapy could be authorized under the ODG. In addition, the ODG makes no requirements regarding how recent the imaging needs to be. XX must not realize that SI joint changes do not disappear nor improve with time. Requesting up to date studies is a common ploy used by pre-authorization doctors to justify denial.”

XX noted the patient continued to have neck and back pain 4/10. The patient was stable on current medications. No changes were made to the medications. No additional interventions were recommended. The patient was advised to follow up in one month. XX refilled Norco 10/325 mg and Neurontin 100 mg.

XX performed a reconsideration review and upheld the denial with the following rationale: *“The patient is a male who sustained an injury on XX/XX/XX when he was involved in a motor vehicle rollover accident. He was diagnosed with left SI joint adjacent level disease, left sacroiliac pain and lumbar degenerative disc disease status post surgery. An appeal for inpatient left sacroiliac joint fusion with one day length of hospital stay has been made. The request was previously denied since there was no documentation of exhaustion and failure of recent physical therapy. In addition, updated imaging studies documenting sacroiliac joint spondyloarthropathy were not submitted for review. There is an updated documentation submitted for review including an appeal letter dated xxxxx. Electrodiagnostic studies of the lower extremities showed chronic left L5 radiculopathy and left tibial motor mononeuropathy. A prior history of two lumbar laminectomies with the last one in XX/XXXX was noted. MRI of the lumbar spine showed L4-S1 degenerative disc disease and L5-S1 postsurgical changes. The patient underwent L5-S1 anterior lumbar interbody fusion on XX/XX/XX. X-rays of the lumbar spine office visit showed postsurgical changes. He was treated with medications and physical therapy which provided some relief. He also had left sacroiliac injection on XX/XX/XX which provided 80 percent relief for two months and a left sacroiliac joint injection on XX/XX/XX with relief for approximately three weeks. On follow-up, he complained of left sided low back pain. The patient had been having the sacroiliac related pain for over a year. He had pain with weightbearing in his left leg, and he also had significant pain when he tried to get up from sitting in a chair. Physical examination revealed positive Fortin Finger and FABER's test on the left. Distraction and Posterior Shear tests were positive on the left. Distally, his motor strength and sensation were intact. The appeal letter indicates that the patient continues to experience low back pain. While a surgical intervention is considered, the records submitted for review did not contain specific and updated radiographic findings such as the presence of spondyloarthropathy and ruling out sacroiliac joint disruption (in the absence of major pelvic fracture), degenerative sacroiliitis, and SI joint osteoarthritis. In agreement with the previous determination, the medical necessity of the request has not been substantiated.”*

On XX/XX/XX, the patient continued to reported neck and low back pain. He stated that the injuries affected his daily activities and he did not function as well as before. The pain level was 6/10. The

patient had aberrant behavior at this time. XX diagnosed lumbago and cervicalgia and continued the current medications without changes. XX recommended low impact aerobic exercises. The patient was advised to follow up in one month. The patient was advised to limit activities to comfort and avoiding activities that increased the discomfort.

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

This patient is a gentleman who had a work injury on XX/XX/XX, in which he was the driver that had flipped and the driver was ejected apparently from the vehicle. The records forwarded indicate that the patient had electrodiagnostic study of the left lower extremity to show L5 paraspinal muscle abnormality with possible left tibial motor neuropathy of uncertain etiology.

A subsequent MRI XX/XX/XX, showed the presence at L5-S1 of disc desiccation and disc space narrowing with Modic endplate changes. There was also lateral recess narrowing. There was enhancement of the laminectomy defects at the lower level along left side of the thecal sac and adjacent to the left S1 nerve root.

On XX/XX/XX, the patient was further evaluated noting the history of lumbar pain of 7 on a 10 scale. The patient had cervical pain 4 on a 10 scale and right shoulder pain of 5 on a 10 scale. This patient's surgical history was positive for right shoulder arthroscopy, right hip replacement, laminectomy, spinal fusion, and presence of discomfort in the low back, SI joints, and buttocks. Straight leg raise showed leg pain to the foot bilaterally. There had been no relief per the patient after the second lumbar laminectomy. XX recommended fusion after discectomy.

On XX/XX/XX, the patient had another decompression at L5-S1 with fusion at that level. This included posterolateral fusion as well as segmental instrumentation of L5-S1. The patient continued to then follow-up. However, the patient continued to also have significant symptoms of 7 on a 10 scale as noted on the XX/XX/XX, visit. The patient had a positive Faber test allegedly as well as a Fortin finger test. On XX/XX/XX, XX performed a left SI joint injection. Therapy was done at XX. The patient was noted to have an antalgic gait. The patient was still having significant residual pain per their handwritten summary. This was in the low back and over the pelvis region as well. The follow-up visit reported an 80% relief of the back pain and that the patient was very happy with the results of the injection up until late XX. *(Reviewer's comment: This does not appear consistent with the therapy notes).*

The patient then had another left SI joint injection under fluoroscopy. However, the patient was seen, noting that the patient had received a "trigger point injection with minimal relief".

The straight leg raise was noted to be positive on the left. XX diagnosed low back pain, lumbago, and cervicalgia but did not diagnose any SI joint dysfunction.

The patient then continued XX on monthly follow-up visits with medication management.

There were utilization review notes forwarded as well where XX as well as XX looked at the forwarded records and opined that the proposed SI fusion did not meet medical necessity requirements.

The report of benefit and that documented by other persons in the file obviously are inconsistent. This patient has had multiple interventions of multiple areas of his body. Nothing has seemed to be definitive. The progression now of proposal for a left SI fusion is not consistent with result that has been obtained on the previous SI injections. Thus, the proposed surgical fusion of the left SI joint does not appear consistent with evidence based medicine and is not consistent as a medical necessity. Thus, the request as submitted is denied and the previous adverse determinations are upheld.

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

ODG – Official Disability guidelines and Treatment Guidelines