Notice of Independent Review Decision

Case Number: XXXXXX

Date of Notice: XXXX

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Review Outcome

Description of the service or services in dispute:

Fusion of right sacroiliac with instrumentation as outpatient

27279 - Minimally invasive sacroiliac joint fusion with instrumentation (c-arm imaging)

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

Board Certified Orthopedic Surgery

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

☐ Upheld

☑ (Disagree)

Overturned

(Agree)

☐ Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)

XX who was diagnosed with dorsopathy, sacroiliac instability, postlaminectomy syndrome, depressive disorder, arthrodesis status, lumbar spine radiculopathy and low back pain.

On XXXX, XX was seen by XX for a follow-up of the sacroiliac instability and lumbar spine radiculopathy. XX had right midline lumbar spine pain. The pain was rated as 7/10 and radiated down to the right posterior thigh and to the lateral calf to the dorsal of right foot to the pinkie and ring toe of right foot, with numbness. On examination, there was healed midline and left iliolumbar spine scar. At the lumbar spine, there was tenderness of the posterosuperior iliac spine. The range of motion of the lumbar spine was 30 degrees flexion and 5 degrees extension of the lumbar spine. Neurologically, the bilateral ankle reflexes were diminished. The compression test and Patrick-Faber test were positive. XX walked with an antalgic gait and had difficulty

standing or sitting for prolonged periods at the time. XX again had marked tenderness over the bilateral posterior superior iliac spines, worse on the right compared to the left and had positive provocative findings to the bilateral sacroiliac joints. In particular, on the right side, there was a positive Fortin test, a positive Faber test and a positive thrust test. The assessment was sacroiliac instability, lumbar radiculopathy, low back pain, hypertensive disorder, and hypercholesterolemia.

Treatment to date included medications (Norco, Praluent, Tramadol, Tylenol-Codeine, Diazepam, Metoprolol Succinate, Ibuprofen and Cyclobenzaprine), injections (Toradol), right sacroiliac joint block, five back surgeries and physical therapy. The surgical interventions included laminectomy defect surgery (L3-L4, L4-L5 and L5-S1), posterior fusion (L3-L4, L4-L5 and L5-S1), interbody fusion (L3-L4, L4- L5 and L5-S1) and surgery for pedicle screws (L3-L4, L4-L5 and L5-S1).

A lumbar spine x-ray dated XXXX showed fifth non-rib bearing lumbar vertebrae and preservation of lumbar lordosis. On XXXX, a nuclear medicine myelogram perfusion stress showed 8/10 left-sided chest pressure as well as T-wave inversion. On XXXX, an x-ray of the lumbar spine showed clear evidence of disruption of the fusion at the L4-L5 level with a solid healed fusion below that (at L5- S1 levels). With flexion and extension, there was widening posteriorly at the L4-L5 level that would suggest a nonunion at that level.
On XXXX, x-rays of the lumbar spine done revealing very satisfactory showing good placement of the hardware from L3-L4 levels. On XXXX, x-ray of the lumbar spine showed five non-rib bearing lumbar vertebrae.

On XXXX, a utilization review by XX indicated that the request for surgery could not be supported based on the documentation provided. Sacroiliac fusion was not recommended routinely by the guidelines and should be recommended on a case- by-case basis as the last line of therapy. It was recommended for those with sacroiliac joint infection, tumor involving the sacrum, disabling pain due to sacroiliitis due to spondyloarthropathy or sacroiliac pain due to severe traumatic injury, as well as conditions associated with multi-segmental spinal constructs. There was documentation that XX had lumbar postlaminectomy syndrome and chronic pain, without a true objective documentation to support sacroiliac mediated pain. There was no clear indication that other etiologies of pain had been ruled out. There was no documentation of the failure of non-operative care to include formal physical therapy, trial injection or a diagnostic injection, to support the medical necessity for the proposed surgery. Additionally, the guidelines note that the examination findings, history, and diagnostic evaluations should be consistent with sacroiliitis in order to propose the diagnosis of symptomatic sacroiliitis. Radiology report of diagnostic imaging was not provided. The case was discussed with XX. XX had repaired a nonunion of the fusion done by a different surgeon and stated XX no longer had back pain. XX had examination findings and had a diagnostic injection into the sacroiliac joint that had proven the source of the pain. That was a controversial procedure. XX opined that the request for fusion of the right sacroiliac with instrumentation (C-arm imaging) as an outpatient was not certified.

A reconsideration utilization review dated XXXX by XX, indicated that reconsideration for fusion of the right sacroiliac joint with instrumentation (c-arm imaging), unspecified was not certified. According to the Official Disability Guidelines, sacroiliac fusion was recommended on a case-by-case basis as a last line of therapy with the ongoing symptoms, corroborating physical examination findings and imaging after the failure of non-operative care for those with sacroiliac joint infection, tumor involving the sacrum, disabling pain due to sacroiliitis due to spondyloarthropathy, sacroiliac joint pain due to severe traumatic injury and/or conditions associated with multi-segmental spinal constructs. The clinical documentation submitted for the review indicated that XX had low back pain and tenderness to palpation with restricted function and positive provocative test findings despite non- operative care. However, there was no documentation noting he had such conditions as outlined by the guidelines and imaging studies were not provided to the region. Consequently, the request was not supported. As such, the requested reconsideration for fusion of the right sacroiliac joint with instrumentation (c-arm imaging), unspecified was not medically necessary.

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

The request for right sacroiliac joint fusion with instrumentation and imaging is supported as medically necessary and the prior determinations are overturned. The submitted clinical records indicate the patient is status post lumbar fusion. At one point the patient was reported to pseudoarthrosis requiring additional surgery. Peer-reviewed evidence on sacroiliac joint fusion is well- established. The requestor reports the patient had benefit from an Si injection. Physical exam is also highly suggestive. Therefore, sacroiliac joint fusion is indicated.

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
- ☐ AHRQ-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

  ODG® 2018. Official Disability Guidelines® (23rd annual edition) & ODG® Treatment in Workers' Comp (16th annual edition): Hip Chapter. SI Joint Fusion
- ☐ 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 Medical Literature (Provide a description)
- ☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)