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Description of the service or services in dispute:

Bilateral sacroiliac joint injection with fluoroscopy

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

Board Certified Anesthesiology

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

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

Patient Clinical History (Summary)

The patient is a XXXX who was diagnosed with post lumbar laminectomy, L2 through S1 fusion. On XXXX, per a history and physical report by XXXX, the patient was injured on XXXX. XXXX while working for XXX in XXXX. Evidently, XXXX had pain in the thoracic and lumbar segment with thoracic radiculopathy, cord compression at T7-T8 and T8-T9 as well as T3-T4 stenosis. The pain was generated from the thoracic level and there was a previous L2 through S1 fusion along with development of severe facet arthritis. On physical examination, the pain was rated as 6/10 with sitting, standing and with activity. Examination of the spine revealed increased pain with lumbar extension over the right and left sacroiliac joints. There was decreased sensation in the left anterior and posterior thigh. Fortin's sign, Compression test and Distraction tests were positive. Patrick's test was positive bilaterally. Achilles was +1 bilaterally.

Treatment to date consisted of medications and injections.

On XXXX, the patient underwent bilateral sacroiliac joint injection and received 60% improvement.

On XXXX, the patient underwent a thoracic epidural block at T11-T12 and received 40% improvement.

On XXXX, XXXX had bilateral T12-L1 lumbar facet medial branch block and posterior primary ramus block. XXXX received 70% improvement. On XXXX, XXXX underwent bilateral sacroiliac joint injections, where XXXX got 50 % improvement. On XXXX, the patient underwent bilateral T12-L1 lumbar facet rhizotomy. There was no improvement noted.

An undated lumbar and thoracic myelography showed a dorsal compression/displacement of the contrast column in the thoracic and lumbar spine at T11-T12 and L1-L2 levels. There were features of borderline spinal canal stenosis at L1-L2. The bilateral nerve root sleeve filling appeared slightly diminished at L4-L5 and L5-S1. There was dorsal displacement of the contrast column at T3-T4, T7-T8, T8-T9 and T9-T10. A diminished nerve root sleeve filling was suggested at those levels, as well as from the T10-T11 to the T12-L1 level.

An undated post-myelogram CT scan of the lumbar spine revealed at T12-L1 and L1-L2, a 2-3 mm broad-based soft tissue disc protrusion effacing the thecal sac. There was bilateral right greater than left foraminal narrowing, along with borderline spinal canal stenosis. Minimal retrolisthesis of L1 relative to L2 was seen. At L2-L3 and L3-L4, there was a stable appearing posterior lateral intersegmental fusion with minimal right facet arthropathy and minimal right foraminal narrowing. At L4-L5 and L5-S1, there was a broad-based laminectomy defect in the posterolateral osseous fusion. There was minimal dorsal left greater than right foraminal narrowing.

Per a utilization review determination letter dated XXXX by XXXX (Pain Management), the request for bilateral sacroiliac joint injections was denied. It was determined that the services provided or proposed to be provided were not medically necessary or were experimental or investigational in nature.

Per a letter dated XXX by XXXX (Anesthesiology), the reconsideration request for bilateral sacroiliac joint injection was denied/non-certified. The request was not medically necessary. Rationale: "In my Judgment, the clinical information provided does not establish the medical necessity of this request. In this case, the provider is requesting bilateral sacroiliac Joint injections. As per evidence based guidelines, SI joint Injections are not recommended for either diagnostic or purposes and may be warranted to rule out the need for fusion. The claimant has had a prior SI joint injection, and there was no rationale to repeat. There are no exceptional circumstances documented. Since the sacroiliac joint injection is not medically necessary, there is no rationale to proceed with fluoroscopy. Therefore, medical necessity has not been established for bilateral sacroiliac joint injection (CPT Codes: 27096 Injection of radiopaque substance for Arthrography of sacroiliac joint) and fluoroscopy (CPT Codes: 77003 Fluoroguide for spine inject)."

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

Two prior reviews correctly identified the key issues with respect to adherence to ODG Criteria.

In XXXX review dated XXXX; it was stated that the site of the neural pain generator was already identified.

In XXXX review, dated XXXX; it was noted that the indication of repeat injection was not clearly apparent.

Furthermore, while SI Joint dysfunction was noted in the patient's records, the pathophysiology of the dysfunction was not stated. The patient had two prior SIJ injections in XXX and XXXX with a positive response but with unknown duration.

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
- ☐ 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
  Sacroiliac injections, diagnostic
  ODG Treatment Integrated Treatment/Disability Duration Guidelines
  Hip and Pelvis (Acute and Chronic)
- ☐ 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)