CASEREVIEW

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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Right Sacroiliac Joint Injection with Fluoroscopy and Conscious Sedation

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The physician specializes in Physical Medicine and Rehabilitation with over 20 years of experience.

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:
☒ Upheld (Agree)
Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:
This claimant is a XXXX who was injured on XXXX. While at work XXXX had to XXXX and developed pain in XXXX back. The problem is related to a chronic condition.

On XXXX, the claimant presented to XXXX with constant, moderate mid-low back pain rated 7/10. XXXX described the symptoms as sharp, dull, and shooting. The symptoms were made worse with sitting, bending, and twisting. On examination strength and sensation were grossly intact in bilateral lower extremities. XXXX had significant discomfort with all movements. Flexion of the lumbar spine was 2 inches above XXXX knees with no pain with extension. XXXX had tenderness over XXXX lumbar paraspinal musculature. Negative straight leg raise. Reflexes were normal and symmetric. Assessment: Lumbar sprain. Plan: Recommended rest, ice, and heat. XX 50 mg tablets were prescribed. A XX was prescribed. XX 10 mg tablets were prescribed.

On XXXX, the claimant presented to XXXX feeling 80% better since the last visit. Plan: Recommended several sessions of physical therapy because of XXXX muscular tightness.

On XXXX, the claimant presented to XXXX with worsening symptoms. Pain was moderate with a rating of 6/10. XXXX reported having attended several sessions of PT, but pain worsened with radiation down XXXX right leg. Most severe was in XXXX right hamstring. XXXX reported taking XX in the morning and XX at night. On examination XXXX was having trouble sitting comfortably. Positive straight leg raise on the right. Reflexes were normal and symmetric in bilateral lower extremities. XXXX had an antalgic gait. Mark limitation in ROM of the lumbar spine in flexion and extension. Plan: Recommended MRI of lumbar spine. XX 15 mg prescribed. Continue light duty.

On XXXX, MRI Lumbar Spine, Impression: 1. No lumbar vertebral compression fracture or marrow

signal abnormality. 2. The intervertebral disks are well-hydrated and normal in height. 3. No bulge/herniation, canal stenosis or foraminal narrowing is seen in the lumbar spine. There is a 7 mm synovial cyst along the posterior margin of the left facet joint at L4-L5.

On XXXX, the claimant presented to XXXX with no change in symptoms. Pain was moderate with rating of 4/10. On examination XXXX had trouble walking. XXXX had tenderness over XXXX right sacroiliac joint. Positive Faber sign on the right. XXXX was able to flex just below XXXX knees. Positive pelvic compression test. Plan: Recommended diagnostic/therapeutic right sacroiliac joint injection. Remain on restricted duty.

On XXXX performed a UR. Rationale for Denial: This patient had to restrain a student and developed low back pain. XXXX stated XXXX had a chronic problem on XXXX. XXXX had a lumbar MRI that showed a synovial cyst at the L4-5 facet joint. XXXX has had radiating pain to XXXX right leg. Essentially all of XXXX office notes discuss XXXX lumbar spine. Per ODG guidelines the request for Right Sacroiliac Joint Injection with Fluoroscopy and Conscious Sedation is not medically necessary.

On XXXX, XXXX performed a UR. Rationale for Denial: In this clinical setting, there is no evidence of inflammatory pathology in the sacral region. Also, the documentation does not substantiate the duration and frequency of the provided physical therapy. Further, as per the ODG guideline, the sacroiliac injection is not recommended. Also, it was not clear if image-guided intra-articular diagnostic injections of a local anesthetic predicted a positive response to a therapeutic agent. Therefore, the request for right sacroiliac joint injection with fluoroscopy and conscious sedation is not medically necessary and appropriate at this time.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
Determination: Denial of Right Sacroiliac injection with fluoroscopy and conscious sedation is UPHELD/AGREED UPON since it is not recommended by ODG for non-inflammatory pathology, and there is lack of clinical information. There is a question as to the differential diagnosis of facet irritation given radiating right lower extremity pain, MRI finding of synovial cyst right L4-5 facet joint and no physical exam specifically regarding the facet joints as a pain generator. There is also question as to the specifics of previous physical therapy addressing the SI joint, and instruction in and compliance with a home exercise program specifically including the SI joint.

Additionally, there is question as to the clinical rationale for the request for conscious sedation. Therefore, the request for Right Sacroiliac injection with fluoroscopy and conscious sedation is not medically necessary at this time.
PER ODG:

Sacroiliac joint injections (SJI)
Body system:
Low Back
Treatment type:
Injections
Related Topics:
See the Hip and Pelvis Chapter.

Not Recommended (generally) NR
Not recommended for non-inflammatory sacroiliac pathology. Recommend on a case-by-case basis for inflammatory spondyloarthropathy (sacroiliitis).

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 (PROVIDE A DESCRIPTION)**

☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**