Parker Healthcare Management Organization, Inc.

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IRO Cert#5301

DATE OF REVIEW: MAY 21, 2018 AMENDED ON MAY 22, 2018

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Medical Necessity of the proposed Bilateral Sacroiliac Joint under Fluoroscopy, CPT codes 27096B, 77003

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer is Board Certified in Physical Medicine and Rehabilitation and is engaged in the full time practice of medicine.

REVIEW OUTCOME
Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:
XX Upheld (Agree)

☐ Overturned (Disagree)

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

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a XXXX who was injured on XXXX, when XXXX. The claimant was diagnosed with post-laminectomy syndrome, radiculopathy, and spondylosis of the lumbar spine, and chronic pain syndrome. The claimant had undergone multiple lumbar surgeries, in XXXX, and an L2-L3 laminectomy in XXXX. A dorsal column stimulator was implanted in XXXX and a XX Pump was implanted in XXXX. Current medications included XX, XX, and XX. Diagnostic studies included a CT scan of the lumbar spine on XXXX, which reported postsurgical changes at L4-L5 and L5-S1, thecal sac decompressed at operative levels with evidence of peripheral clumping, and displacement of the lower lumbosacral nerve roots. There were postsurgical changes at L2-L3 and varying degrees of degenerative changes at the operative levels. An evaluation on XXXX, noted the claimant complained of low back pain. Prior treatment included lumbar epidural steroid injections, lumbar medial branch blocks, and facet rhizotomy. On physical examination, there was tenderness over the right and left L5-S1 facet and increased pain with lumbar extension. Motor strength was 5/5. There were no sensory deficits. Straight leg raise testing was negative. Right and left sacroiliac joint tenderness was noted. Fortin's sign was positive. There was positive compression test and positive Patrick's test of the right and left sacroiliac joints. Patellar reflex was trace on the right and 1+ on the left. Achilles reflex was 1+ bilaterally.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.
RATIONALE: The request was previously noncertified by XXXX on XXXX, due to the lack of evidence of sacroiliitis on examination and imaging. Additional documentation included the evaluation by the treating provider dated XXXX. The previous noncertification is supported. The guidelines do not

support therapeutic sacroiliac joint injections for non-inflammatory sacroiliitis pathology. There is no diagnostic imaging reporting any inflammatory sacroiliitis or any laboratory testing or physical examination. The Official Disability Guidelines do not recommended sacroiliac joint injections without evidence of sacral spondyloarthropathy or sacroiliitis and per the submitted documentation the claimant reported continued back pain. The submitted imaging reports demonstrated postsurgical changes at L4-L5 and L5-S1. However, due to the request injection was not supported. Therefore, due to the lack of findings to support medical necessity, the request for bilateral sacroiliac injection under fluoroscopy is not certified.

Official Disability Guidelines
Hip and Pelvis (updated 05/04/18)
Sacroiliac injections, therapeutic
Not recommended (neither therapeutic sacroiliac intra-articular nor periarticular injections) for non-inflammatory sacroiliac pathology, based on insufficient evidence. Recommended on a case-by-case basis as injections for inflammatory spondyloarthropathy (sacroiliitis). This is a condition that is generally considered rheumatologic in origin (classified as ankylosing spondylitis, psoriatic arthritis, reactive arthritis, arthritis associated with inflammatory bowel disease, and undifferentiated spondyloarthropathy). Instead of injections for non-inflammatory sacroiliac pathology, conservative treatment is recommended. Current research is minimal in terms of trials of any sort that support the use of therapeutic sacroiliac intra-articular or periarticular injections for non-inflammatory pathology. Below are current reviews on the topic and articles cited. There is some evidence of success of treatment with injections for inflammatory spondyloarthropathy, although most rheumatologists now utilize biologic treatments (anti-TNF and/or disease modifying antirheumatic drugs) for treatment.

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
- ☐ AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- ☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- ☐ INTERQUAL CRITERIA
- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- ☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- ☐ MILLIMAN CARE GUIDELINES
- XX 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)