

## Notice of Independent Review Decision

### DATE OF REVIEW:

08/21/2007

### IRO CASE #:

### DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Bilateral sacroiliac (SI) joint Injections with Bilateral Arthrogram under fluoroscopy.

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

Board Certified Doctor of Osteopathy, Boarded in Anesthesiology and Specializing in Pain Management.

### REVIEW OUTCOME

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

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

**Bilateral sacroiliac (SI) joint Injections with Bilateral Arthrogram under fluoroscopy is not medically necessary.**

### INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Case Report dated 08/08/07
- Referral dated 08/08/07
- Work Status Report dated 03/03/07
- DWC: Notice To, LLC Of Case Assignment dated 08/07/07
- DWC: Confirmation Of Receipt Of A Request For A Review dated 08/03/07
- LHL009: Request For A Review By An Independent Review Organization dated 08/03/07
- Letter dated 08/01/07 from M.D.
- Notification of Determination dated 07/26/07 from M.D.
- Pain Institute: Preauthorization Request Form dated 07/23/07
- Pain Institute: Letter dated 07/16/07 from M.D.
- M.D.: Office Follow Up notes dated 06/26/07, 05/08/07
- M.D.: Referral Note dated 05/16/07
- M.D.: Physician Report dated 04/12/07
- M.D.: Report dated 03/29/07
- M.D.: Industrial-Motor Vehicle Accident Follow up Report dated 03/03/07
- Medical Center: Admission/Registration Record dated 02/01/07
- Medical Center: General Conditions of Admission, Admission Record dated 02/01/07

- Medical Center: Emergency Department Physician Record dated 02/01/07
- Medical Center: Emergency Department Nursing Record dated 02/01/07
- Medical Center: Emergency Physician Record dated 02/01/07
- Medical Center: Consent for Treatment dated 02/01/07
- Medical Center: Discharge Instructions dated 02/01/07
- Medical Center: Consent dated 02/01/07
- Health Systems: Addendum History and Physical Exam report dated 12/21/06 from M.D.
- Spine Care: Chart Note dated 09/22/06 from M.D.

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The injured individual is male with date of injury xx/xx/xx. The injured individual ultimately had a lumbar fusion in 03/2006. He had medications and aqua treatment after the lumbar fusion. He was seen in 05/2007 and his surgeon recommended hardware blocks for possible hardware removal but he never returned to him. Dr. saw him in 07/2007 and noted leg pain more than back pain, pain with flexion more than with extension, negative Patrick, and negative Faber. The only positive sacroiliac (SI) finding was tenderness over the joint. The attending physician (AP) recommended a spinal cord stimulator (SCS), pain program, and SI injection.

### **ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.**

The requested injections are denied because the injured individual had multiple negative SI joint testing results. He had negative Patrick and negative Faber. He had pain worse with lumbar flexion (SI dysfunction produces pain on extension) and he had more leg pain than back pain (SI produces back pain). Also, he was told in 05/2007 to consider hardware removal but he never returned for that. For all these reasons, the SI injection with arthrogram is not considered medically necessary.

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

#### **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

ODG 2007: Recommended as an option if failed at least 4-6 weeks of aggressive conservative therapy as indicated below. Sacroiliac dysfunction is poorly defined and the diagnosis is often difficult to make due to the presence of other low back pathology (including spinal stenosis and facet arthropathy). The diagnosis is also difficult to make as pain symptoms may depend on the region of the SI joint that is involved (anterior, posterior, and/or extra-articular ligaments). Pain may radiate into the buttock, groin and entire ipsilateral lower limb, although if pain is present above L5, it is not thought to be from the SI joint.

Innervation: The anterior portion is thought to be innervated by the posterior rami of the L1-S2 roots and the posterior portion by the posterior rami of L4-S3. although the actual innervation remains unclear. Anterior innervation may also be supplied by the obturator nerve, superior gluteal nerve and/or lumbosacral trunk. (Vallejo, 2006) Other research supports innervation by the S1 and S2 sacral dorsal rami.

Etiology: includes degenerative joint disease, joint laxity, and trauma (such as a fall to the buttock). The main cause is SI joint disruption from significant pelvic trauma.

Diagnosis: Specific tests for motion palpation and pain provocation have been described for SI joint dysfunction: Cranial Shear Test; Extension Test; Flamingo Test; Fortin Finger Test; Gaenslen's Test;

Gillet's Test (One Legged-Stork Test); Patrick's Test (FABER); Pelvic Compression Test; Pelvic Distraction Test; Pelvic Rock Test; Resisted Abduction Test (REAB); Sacroiliac Shear Test; Standing Flexion Test; Seated Flexion Test; Thigh Thrust Test (POSH). Imaging studies are not helpful. It has been questioned as to whether SI joint blocks are the "diagnostic gold standard." The block is felt to show low sensitivity, and discordance has been noted between two consecutive blocks (questioning validity). (Schwarzer, 1995) There is also concern that pain relief from diagnostic blocks may be confounded by infiltration of extra-articular ligaments, adjacent muscles, or sheaths of the nerve roots themselves. Sacral lateral branch injections have demonstrated a lack of diagnostic power and area not endorsed for this purpose. (Yin, 2003)

Treatment: There is limited research suggesting therapeutic blocks offer long-term effect. There should be evidence of a trial of aggressive conservative treatment (at least six weeks of a comprehensive exercise program, local icing, mobilization/manipulation and anti-inflammatories) as well as evidence of a clinical picture that is suggestive of sacroiliac injury and/or disease prior to a first SI joint block. If helpful, the blocks may be repeated; however, the frequency of these injections should be limited with attention placed on the comprehensive exercise program. (Forst, 2006) (Berthelot, 2006) (van der Wurff, 2006) (Laslett, 2005) (Zelle, 2005) (McKenzie-Brown 2005) (Pekkafahli, 2003) (Manchikanti, 2003) (Slipman, 2001) (Nelemans-Cochrane, 2000) See also Intra-articular steroid hip injection; & Sacroiliac joint radiofrequency neurotomy.

Criteria for the use of sacroiliac blocks:

1. The history and physical should suggest the diagnosis (with documentation of at least 3 positive exam findings as listed above).
2. Diagnostic evaluation must first address any other possible pain generators.
3. The patient has had and failed at least 4-6 weeks of aggressive conservative therapy including PT, home exercise and medication management.
4. Blocks are performed under fluoroscopy.
5. A positive diagnostic response is recorded as 80% for the duration of the local anesthetic. If the first block is not positive, a second diagnostic block is not performed.
6. If steroids are injected during the initial injection, the duration of pain relief should be at least 6 weeks with at least > 70% pain relief recorded for this period.
7. In the treatment or therapeutic phase (after the stabilization is completed), the suggested frequency for repeat blocks is 2 months or longer between each injection, provided that at least >70% pain relief is obtained for 6 weeks.
8. The block is not to be performed on the same day as a lumbar epidural steroid injection (ESI), transforaminal ESI, facet joint injection or medial branch block.
9. In the treatment or therapeutic phase, the interventional procedures should be repeated only as necessary judging by the medical necessity criteria, and these should be limited to a maximum of 4 times for local anesthetic and steroid blocks over a period of 1 year.