

MATUTECH, INC.

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AMENDED: 7/24/07

Notice of Independent Review Decision

DATE OF REVIEW: JULY 20, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Bilateral sacroiliac (SI) joint injections x2 and TPI x6 to back

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

The physician providing this review is a Doctor of Medicine (M.D.). The reviewer is national board certified in Physical Medicine and Rehabilitation as well as Pain Medicine. The reviewer is a member of International Spinal Intervention Society and American Medical Association. The reviewer has been in active practice for ten years.

REVIEW OUTCOME

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

Upheld (Agree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

M.D.:

- Office notes (04/03/07 – 05/22/07)

M.D.:

- Office notes (06/02/99 - 07/25/01)
- FCE (06/07/01)
- Therapy (08/21/01)
- Operative Notes (05/11/00 – 11/16/00)
- Diagnostics (02/15/00 – 03/24/00)

Office notes (03/16/06 – 05/22/07)

Utilization reviews (05/09/07 - 06/01/07)

PATIENT CLINICAL HISTORY [SUMMARY]:

This male was injured while working for Hospital. While trying to stop an adolescent from committing suicide, he chased the adolescent through the complex and jumped off a 9' wall. He landed on his feet and felt pain and spasms in his lower back.

1995 – 1998: Treatment history is not available.

1999 – 2000: In 1999, the patient was evaluated by, M.D., a neurosurgeon, for persistent low back pain radiating to the left lower extremity associated with a tingling sensation. Dr. noted the following: *After the injury, the patient was treated with lumbar epidural steroid injections (ESI) without any improvement. Magnetic resonance imaging (MRI) revealed disc herniations at L4-L5 and L5-S1. In August 1995, he underwent microdiscectomy at the L4-L5 and L5-S1 levels. Subsequently, he underwent anterior interbody fusion with cortical bone rings followed by posterior facet screws at these levels due to persistence of symptomatology. Recently, he was found to have an L5 nerve root irritation on electrodiagnostic study. MRI of the lumbar spine showed an incomplete fusion mass at L4-L5 and L5-S1. Computerized tomography (CT) myelogram revealed nerve root entrapment at the L3-L4 and L4-L5 levels as well as broken screws at the L4-L5 level with pseudoarthrosis. Dr. diagnosed lumbar pseudoarthrosis at L4-L5, lumbar stenosis at L3-L4, and failed back syndrome.*

In July 1999, he noted that the patient had been recently involved in a motor vehicle accident (MVA) and had developed some right paraspinal muscular discomfort. In September, Dr. saw him two weeks status post posterior decompression at the left L3-L4 and L4-L5 levels followed by fusion from L4 through sacrum. Postoperatively, the patient did well, but complained of left paraspinal region discomfort for which Dr. placed him on anti-inflammatory medications.

A lumbar myelogram/CT scan obtained in February 2000 revealed a large 1-cm soft tissue density in the left lateral aspect of the spinal canal at L3-L4 possibly representing epidural fibrosis or element of disc herniation; slight to mild 2-3 mm retrolisthesis of L4 on L5 with a small ventral epidural defect and moderate-sized ventral epidural defects at L3-L4 with mild rocking motion at L3-L4 on flexion and extension. A lumbar MRI with gadolinium was obtained that revealed a large left-sided disc herniation at L3-L4 with impingement of the thecal sac, lateral recess, and left neural foramen; and mild bilateral foraminal stenosis at L4-L5.

On May 11, 2000, Dr. performed left L3-L4 microdiscectomy and microforaminotomy. Postoperative x-rays showed collapse of the intervertebral disc space at L3-L4 lateralizing towards the left. The patient had become depressed and had suicidal thoughts due to persistence of symptomatology. Dr. recommended psychiatric consultation. On November 16, 2000, he performed anterior radical discectomy at L3-L4, anterior lumbar arthrodesis at L3-L4, revision of spinal instrumentation with removal of old hardware and placement of new hardware, and posterior lumbar arthrodesis at L3-L4.

2001: From February through August, the patient attended physical therapy (PT) followed by a STEP program. Dr. noted numbness in the left anterolateral aspect of the thigh and felt that the low back discomfort was probably coming from the

sacroiliac (SI) joints. He referred the patient to Dr. for pain management. On July 25, 2001, Dr. assessed maximum medical improvement (MMI) and assigned 5% whole person impairment (WPI) rating. In the interim, the patient was treated with a Botox injection into the right SI joint with relief of pain.

2002 – 2005: Treatment history was not available.

2006: M.D., performed a required medical evaluation (RME) and rendered the following opinions: (1) Treatment would be necessary for maintenance care on an indefinite basis. (2) Additional surgery was not required. However, if the patient developed significant enough stenosis or compression of the exiting nerve root at the L2-L3 level, then possible surgical decompression could be required if he failed to respond to conservative measures to treat his left leg radiculopathy. (3) Additional formal PT, chiropractic therapy, DMEs, or diagnostic studies would not be needed. (4) He should be on a home-based program of exercise. (5) The occasional use of narcotics such as hydrocodone and muscle relaxer such as Soma would be appropriate for acute flare-ups of his lumbar spine. (6) He was not functionally employable at this point and would not be in the future.

2007: On April 3, 2007, M.D., noted that recently, Dr. had performed Botox injections, but with minimal relief. Examination revealed limited lumbar range of motion (ROM), pain to palpation of the left SI joint, positive FABER and Gaenslen's on the left. Dr. diagnosed failed back syndrome and left SI joint dysfunction; continued Soma and Norco; and recommended SI joint injections x2 and ligament injection x6.

On May 9, 2007, outpatient bilateral SI joint injections x2 and TPIs x6 were nonauthorized. The rationale: *The patient was injured about 12 years ago. The note of May 1, 2007, indicated that there was significant low back pain with pain radiating to the SI joint. There was no mention of myofascial trigger points on exam. ODG guides state that in the absence of myofascial pain syndrome, TPIs are not recommended.*

On May 22, 2007, Dr noted the similar physical examination findings and assessed chronic low back pain with left SI joint dysfunction. He recommended left SI joint injections from diagnostic as well as therapeutic standpoint.

On June 1, 2007, reconsideration for the request was nonauthorized. The rationale: *There is no documented evidence of myofascial trigger points on examination. The bilateral SI injections and trigger point injections are not, according to documentation, supported by ODG in the absence of myofascial trigger points as well as the absence of need to undergo outpatient bilateral SI joint injections x2, due to the fact that the patient only had findings of SI joint dysfunction on the left hand side according to the documentation.*

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

CONCURRENT TREATMENT FOR MULTIPLE BODY PARTS IS REQUESTED. ODG HAS A CLEAR POSITION REGARDING THIS TYPE OF REQUEST.

RIGHT SIJ IS NOT REPORTED TO BE PAINFUL BY REQUESTOR AND DOES NOT APPEAR TO MEET CRITERIA FOR MEDICAL NECESSITY.

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

- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**

Schwarzer AC, Aprill CN, Bogduk N. The sacroiliac joint in chronic low back pain. *Spine*. 1995 Jan 1;20(1):31-7.