



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION Workers' Compensation Health Care Non- network (WC)

12/10/2008

DATE OF REVIEW: 12/10/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Bilateral SI joint injection

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

Texas State Licensed MD Board Certified Physical Medicine & Rehab physician

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

Upheld

(A

(Disagree) Overturned
(Disagree)

Partially Overturned (Agree in part/Disagree in part)

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.

PATIENT CLINICAL HISTORY:

This patient sustained a xx/xx/xx occupational lower back lifting injury. She failed conservative treatment and underwent an L-3 through S-1 back fusion surgery. She is currently under the care of MD at six-month intervals primarily for prescribed medication management of chronic low back pain. Dr. is requesting bilateral SI joint injections under fluoroscopy based upon palpatory findings of bilateral SI joint tenderness and a FABER test exquisitely positive on the left and mildly positive on the right.

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

The requested bilateral SI joint injections under fluoroscopy is not approved based upon ODG Guidelines as the claimant does not satisfy the criteria for these particular requested injections, and furthermore, there is controversy with regard to the therapeutic benefit of this procedure.

The ODG criteria for SI joint injections or blocks is as follows:

1. The history and physical should suggest the diagnosis with documentation of at least three positive examination findings as listed – cranial shear test, extension test, flamingo test, Fortin finger test, Gaenslen's test, Gillet's test, Patrick's test or FABER test, pelvic



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compression test, pelvic distraction test, pelvic rock test, resisted abduction test, sacroiliac shear test, standing flexion test, seated flexion test, and thigh thrust test.

2. Diagnostic evaluation must first address any other possible pain generators.
3. The patient has failed at least 4-6 weeks of aggressive conservative therapy including: PT, home exercise, and medication management.
4. The 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 greater than 70% pain relief record during this period.
7. In the treatment or therapeutic phase (after the stabilization is completed), the suggested frequency for repeat blocks is two months or longer between each injection, provided that at least greater than 70% pain relief is obtained for 6 weeks.
8. The block is to not 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 procedure should be repeated only as necessary judging by the medical necessity criteria, and these should be limited to a maximum of four times for local anesthetic and steroid blocks over a period of one year.

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



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- 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)**