

PRIME 400
LLC

240 Commercial Street,
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Notice of Independent Review
Decision

DATE OF REVIEW: OCTOBER 28, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

SI Injection, Outpatient

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

MD, Board Certified Orthopedic Surgeon

REVIEW OUTCOME

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

- Upheld (Agree)
- 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.

The reviewer finds that medical necessity does not exist for SI Injection, Outpatient.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a xx year old female who sustained a back injury on xx/xx/xx when a walk-in refrigerator door closed on her. An initial x-ray taken at the time of injury showed a normal lumbar spine. A MRI of 06/05/07 revealed a disc bulge at L5-S1 with the exiting L5 dorsal root ganglia contacted and partially compressed. There was also a disc bulge at L4-5 mildly encroaching on the neural foramina.

Dr. started treating the claimant on 09/19/07 for constant back pain that went into the bilateral lower extremities the right greater than the left. He recommended an epidural at he levels for L4-5 and L5-S1. At that time the claimant was four months post injury

and still symptomatic. The diagnosis was disk bulge at L4-5, L5-S1.

The claimant received an epidural injection on 01/18/08. Dr. saw the claimant on 01/29/08. The claimant reported the injection made her symptoms worse. The pain was coming from the hip area. It was felt a sacroiliac joint injection would be helpful since the disk was not the source of pain.

An independent medical exam was performed 05/20/08 by Dr. On examination there was no objective evidence of residual from injury. The basis for ongoing pain was not evident to him. The x-ray of the right hip was normal.

Dr. examined the claimant on 06/10/08, four weeks after the sacroiliac injection, the claimant reported 60-70 per cent improvement and she requested another injection.

Dr. performed a designated doctor evaluation on 08/09/08. He noted that the claimant had been treated with therapy and was working. His opinion was that she had reached maximum medical improvement on 08/09/08.

On 09/11/08 Dr. 's notes stated the claimant had received a second sacroiliac injection that had helped. She still was having persistent back pain. Dr. felt the claimant needed another sacroiliac injection. The diagnosis was disk bulge L4-5, L5-S1 and right sacroiliac pain.

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

Request was for sacroiliac injection as an outpatient. ODG guidelines were used. The claimant underwent a sacroiliac injection in June with only 60 to 70 percent improvement on the right.

The claimant has pain radiating to the left side. She underwent an injection on the left. However, there was no documentation of improvement. Per ODG guidelines, there are no positive physical findings. The first injection only resulted in 60 to 70 percent relief. ODG guidelines state that a positive diagnostic response is recorded as 80 percent relief for the duration of a local anesthetic. If the first block did not provide significant relief as described, that being 80 percent, a second diagnostic block is not to be performed. This information is not forth coming in the information provided for this review and as such there is insufficient information to approve the sacroiliac joint injection at this time. The reviewer finds that medical necessity does not exist for SI Injection, Outpatient.

Official Disability Guidelines Treatment in Worker's Comp 2008 Updates. Hip/pelvis. Sacroiliac joint injections 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

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 KNOWLEDGBASE
- 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)