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Notice of Independent Review Decision

DATE OF REVIEW: 09/29/08

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Left SI Joint Injection 27096

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

Board Certified in Physical Medicine & Rehabilitation
Fellowship Trained in Pain Management

REVIEW OUTCOME

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

Denial Upheld

PATIENT CLINICAL HISTORY (SUMMARY):

The employee was reported to have sustained an injury to his low back as a result of work related activity on xx/xx/xx. He reported on that date he was lifting furniture and experienced sudden pain the following morning.

Since that time, the employee reported a flare-up almost every year: about one a month average per year. He reported that the symptoms have been worsening since 01/20/08. He reported that his main pain was in his low back and left buttock. He reported his constant, burning, aching pain increased with prolonged sitting and also when moving from sitting to standing positions. He denied any bowel or bladder dysfunction.

On 05/23/08, the employee was seen by Dr. The employee was reported to have received physical therapy for approximately two to three months in 2005 but none since then.

Carrier records indicate that the employee additionally received physical therapy and chiropractic treatment in 2006 with no treatment being performed in 2007.

The employee is currently being prescribed Vicodin by Dr. The employee has not previously received any injections in the past. He has never been tried on Neurontin or

Lyrica. He has not had any surgeries. He has had no electrodiagnostic studies. His last MRI was in 2005. This study was reported to show T12-L4 with normal disc height and signal intensity with no disc protrusions. At L5-S1, there was partial desiccation with central herniation of 3 mm pressing on the thecal sac and nerve roots bilaterally, slightly more on the right but no canal compromise. X-rays of the lumbar spine revealed mild spondylosis but no fracture or spondylolisthesis. On physical examination, the employee was reported to be 5 feet 8 inches in height and weighed 164 pounds. His lower extremity motor strength is graded as 5/5. He had no focal or sensory deficit. Deep tendon reflexes were 2+ in the bilateral lower extremities. He had full active lumbar range of motion with flexion to about 90 and extension to 30 with no pain. He had positive tenderness with palpation to the bilateral sacroiliac joints, left more than right. He had a positive Gillet test on the left. He had decreased movement of the left SI joint. It was opined that the employee had sacroiliac joint dysfunction and lumbar radiculopathy. The employee was to be referred to physical therapy to work on stretching exercises and strengthening exercises, and would be referred for an MRI of the lumbar spine. He was provided Naprosyn and Lyrica and was to continue Norco. He was to be scheduled for an SI joint injection on the left.

On 07/12/08, the employee was referred for MRI of the lumbar spine. This study reported that the discs were fairly well maintained in appearance about the level of L5. At the level of L4-L5, there was a 2 mm diffuse disc herniation present. At the level of L5-S1, there was a 4 mm central disc herniation extending slightly more to the left of midline. This appeared to have increased slightly from the previous examination.

On 07/24/08, Dr. reviewed a request for left sacroiliac joint injection. Dr. noncertified the request. He noted that the clinical documentation submitted failed to adequately detail physical examination findings consistent with left sacroiliac joint mediated pain and dysfunction. He reported there were also no details regarding previous or ongoing or planned future independent exercise program and/or active physical therapy rehabilitative measures for improving and maintaining function either prior or adjunctively to the proposed invasive procedure.

A request for reconsideration was submitted and reviewed on 08/20/08 by Dr. Dr. reported that the documentation did not support signs or symptoms of sacroiliac dysfunction. He noted that the **Official Disability Guidelines** require that there be at least three signs on examination to decide whether the claimant has a diagnosis of sacroiliac joint dysfunction. As a result of the lack of physical examination findings, Dr. noncertified the request.

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

I would concur with the two previous reviewers that a left sacroiliac joint injection is not medically necessary. The submitted clinical information fails to establish that the employee has evidence of left sacroiliac dysfunction. It is further noted that there are no plain radiographs of the pelvis to support the contention that the employee has sacroiliac dysfunction/degenerative disease. Current evidence-based guidelines require that the employee have clear evidence of sacroiliac dysfunction with three positive findings on physical examination. Any other potential pain generators must be addressed. The employee has had to have failed at least four to six weeks of aggressive conservative therapy including physical therapy and home exercise. The submitted records indicate that the employee has not undergone any active physical therapy since 2007.

Given the lack of objective examination findings and clinical data to establish that the employee has met the **Official Disability Guidelines** requirements, the requested procedure would not be medically necessary.

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

The **Official Disability Guidelines**, 11th Edition, The Work Loss Data Institute.

Sacroiliac joint blocks	<p>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.</p> <p>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.</p>
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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.