



Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 8/24/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a left SI joint injection (27096).

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

The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation. This reviewer also holds an additional board certification in Pain Management. This reviewer has been practicing for greater than 10 years and performs this type of service in his office.

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)

The reviewer disagrees with the previous adverse determination regarding the prospective medical necessity of a left SI joint injection (27096).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:

– Dr.

These records consist of the following (duplicate records are only listed from one source): Records reviewed from – Dr. : Follow-up notes – 1/2/09-8/6/09; Dr. . note – 1/20/09.

Records reviewed from : Patient Treatment History, Denial Letter – 6/15/09 & 7/2/09, ODG – Hip & Pelvis (Acute & Chronic) Chapter.

A copy of the ODG was provided by the Carrier.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient was injured when falling while working. He has undergone lumbar surgery with removal of instrumentation. He has undergone left greater trochanter injections. Left sacroiliac joint sclerosis has been verified via radiographs. Left SIJ block under fluoroscopic guidance was offered on 1/20/09. This provided 80% relief of symptoms with reduction of utilization of narcotics.

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

Given that the criteria for SI blocks per the ODG have been documented, the treatment is medically necessary. Per the ODG: 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.

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). This criterion is not significant at this time. The patient already had a fluoroscopically guided SI block with reduction in the patient's subjective symptoms, reduction of narcotic analgesic usage and improvement in his clinical exam. Flamingo testing was negative after injection whereas it was positive on 1/2/09.
2. Diagnostic evaluation must first address any other possible pain generators. This criterion has been met.
3. The patient has had and failed at least 4-6 weeks of aggressive conservative therapy including PT, home exercise and medication management. This criterion is not documented; however, an initial SI block has been performed and was successful. According to the reviewer's professional opinion, the other criterion must be considered based upon this previous success.
4. Blocks are performed under fluoroscopy. This criterion is met.
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. This criterion has been met.
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. This criterion has been met.
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. This criterion has been met.

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. This criterion has been met.

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. This criterion has been met by the doctor attempting to authorize this procedure.

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
- 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)**