



IRO#
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Plano, Texas 75093
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DATE OF REVIEW: 08/19/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

IRO - Right SI joint injection, Trigger Point injection R piriformis with fluoro and anesthesia

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

This case was reviewed by a Texas licensed MD, specializing in Physical Medicine & Rehabilitation. The physician advisor has the following additional qualifications, if applicable:

ABMS Physical Medicine & Rehabilitation

REVIEW OUTCOME:

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

Upheld

Health Care Service(s) in Dispute	CPT Codes	Date of Service(s)	Outcome of Independent Review
IRO - Right SI joint injection, Trigger Point injection R piriformis with fluoro and anesthesia	27096, 20552, 77003, 00630	-	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

No	Document Type	Provider or Sender	Page Count	Service Start Date	Service End Date
1	Office Visit Report	Anesthesia & Pain Management	7	06/16/2009	07/14/2009
2	Initial Denial Letter		7	06/25/2009	07/10/2009
3	IRO Request	Texas Department of Insurance	13	07/30/2009	07/30/2009

PATIENT CLINICAL HISTORY [SUMMARY]:

Reported injury date is xx/xx/xx. The injured worker complains of low back pain. A note from 6-16-09 and 7-14-09 reported lumbar and SI joint tenderness. There is no objective range of motion loss, no focal neurological deficits, no reported spasms. No discussion of abnormal x-ray or MRI findings. No report regarding use of a home exercise program. The patient is currently on Percocet, Soma, and Hydrocodone.

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

Based upon the available documentation and the ODG Guidelines, I respectfully do not recommend the request for Right SI joint injection, Trigger Point injection R piriformis with fluoro and anesthesia to be reasonable or medically necessary: exhaustion of conservative care in terms of PT and use of a HEP are not documented. Criteria for at least 3 provocative maneuvers for SI pain are not documented. Diffuse tenderness located in the lumbar spine, positive straight leg raise testing, pain with lumbar flexion and extension, no reported focal tenderness over the Piriformis. These exam findings along with no radiographic SI joint pathology are poorly supportive of localized SI joint pain or Piriformis pain.

Piriformis injections	<p>Recommended for piriformis syndrome after a one-month physical therapy trial. Piriformis syndrome is a common cause of low back pain and accounts for 6-8% of patients presenting with buttock pain, which may variably be associated with sciatica, due to a compression of the sciatic nerve by the piriformis muscle (behind the hip joint). Piriformis syndrome is primarily caused by fall injury, but other causes are possible, including pyomyositis, dystonia musculorum deformans, and fibrosis after deep injections. Symptoms include buttock pain and tenderness with or without electrodiagnostic or neurologic signs. Pain is exacerbated in prolonged sitting. Specific physical findings are tenderness in the sciatic notch and buttock pain in flexion, adduction, and internal rotation (FADIR) of the hip. Imaging modalities are rarely helpful, but electrophysiologic studies should confirm the diagnosis, if not immediately, then certainly in a patient re-evaluation and as such should be sought persistently. Physical therapy aims at stretching the muscle and reducing the vicious cycle of pain and spasm. It is a mainstay of conservative treatment, usually enhanced by local injections. Surgery should be reserved as a last resort in case of failure of all conservative modalities. No consensus exists on overall treatment of piriformis syndrome due to lack of objective clinical trials. Conservative treatment (eg, stretching, manual techniques, injections, activity modifications, modalities like heat or ultrasound, natural healing) is successful in most cases. For conservative measures to be effective, the patient must be educated with an aggressive home-based stretching program to maintain piriformis muscle flexibility. He or she must comply with the program even beyond the point of discontinuation of formal medical treatment. Injection therapy can be incorporated if the situation is refractory to the aforementioned treatment program. Injections with steroids, local anesthetics, and botulinum toxin have been reported in the literature for management of this condition, but no single technique is universally accepted. Localization techniques include manual localization of muscle with fluoroscopic and electromyographic guidance, or ultrasound. The piriformis muscle, after localization with a digital rectal examination, can be injected with a spinal needle. Care should be taken to avoid direct injection of the sciatic nerve. (Papadopoulos, 2004) (Kunczewicz, 2006) (Huerto, 2007) See also Psoas blocks.</p>
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><i>Innervation:</i> 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</p>

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. ([Hansen, 2003](#))
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

	<p>injection (ESI), transforaminal ESI, facet joint injection or medial branch block.</p> <p>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.</p>
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A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

ODG:

Hip/Pelvis Chapter

TEXAS DEPARTMENT OF INSURANCE COMPLAINT PROCESS: The Texas Department of Insurance requires Independent Review Organizations to be licensed to perform Independent Review in Texas. To contact the Texas Department of Insurance regarding any complaint, you may call or write the Texas Department of Insurance. The telephone number is 1-800-578-4677 or in writing at: Texas Department of Insurance, PO Box 149104 Austin TX, 78714. In accordance with Rule 102.4(h), a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on 08/19/2009.

