



IRO#
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DATE OF REVIEW: 06/22/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Op Lt SI Joint Injection 27096 (73542 PNR) 62311

Op Piriformis Myofascial Injection (72275 PNR) 20552

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 DO, specializing in Physical Medicine & Rehabilitation, Osteopathy. The physician advisor has the following additional qualifications, if applicable:

ABMS, AOA Physical Medicine and Rehabilitation: Pain Medicine, 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 |
|--|---------------------|--------------------|-------------------------------|
| Op Lt SI Joint Injection 27096 (73542 PNR) 62311 | 62311, 27096, 20552 | - | Upheld |
| Op Piriformis Myofascial Injection (72275 PNR) 20552 | | | |

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

| No | Document Type | Provider or | Page | Service Start | Service End |
|----|---------------|-------------|------|---------------|-------------|
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| | | Sender | Count | Date | Date |
|---|-----------------------------------|---------|-------|------------|------------|
| 1 | IRO Request | TDI | 11 | 06/02/2009 | 06/02/2009 |
| 2 | Letter of reconsideration | Dr. MD | 3 | 05/11/2009 | 05/11/2009 |
| 3 | Preauthorization request | Dr., MD | 1 | 05/06/2009 | 05/06/2009 |
| 4 | Initial and Appeal Denial Letters | | 11 | 05/11/2009 | 05/28/2009 |
| 5 | Office Notes | Dr., MD | 2 | 04/23/2009 | 04/23/2009 |
| 6 | Electrodiagnostic Examination | Dr., MD | 3 | 03/05/2009 | 03/05/2009 |

PATIENT CLINICAL HISTORY [SUMMARY]:

Patient with low back and referred buttock pain. Patient with low back after trying to get up from laying down. Patient reportedly had MRI lumbar in 2008 which showed slight L5-S1 disc bulge. EMG reportedly was abnormal but report is not submitted. Treatments have included medication and lumbar epidural steroid injection. Exam findings reportedly showed buttock tenderness. Patient had one sacroiliac joint injection with 75-90 percent relief for one month.

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

Request does not meet ODG criteria. Sacroiliac joint injection relief lasted for one month at 75-90 percent. Patient needs at least 2 months of relief to consider repeat injection. Performing sacroiliac and piriformis injections at the same time is not diagnostic. Lack of documented piriformis supervised or home exercise and stretching program.

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

: ODG tenth edition:

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 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.

For piriformis injection:

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](#)) ([Kuncewicz, 2006](#)) ([Huerto, 2007](#)) See also [Psoas blocks](#).