

P&S Network, Inc.

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DATE OF REVIEW: 06/24/09

IRO CASE #:

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

This case was reviewed by a Pain Management (Board Certified), Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Injection to right SI joint under fluoroscopy

REVIEW OUTCOME

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

Upheld (Agree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- o Submitted medical records were reviewed in their entirety.
- o Treatment guidelines were provided to the IRO.
- o 03-09-09 Medical report from Dr.
- o 03-23-09 Medical report from Dr.
- o 03-24-09 PT assessment report from, DPT
- o 04-03-09 Pre-authorization Determination Letter from IMO for lumbar PT
- o 04-10-09 Medical report from Dr..
- o 04-20-09 Medical report from Dr
- o 04-24-09 MRI report, lumbar spine, read by Dr.
- o 05-06-09 Medical report from Dr. requesting SI joint injection
- o 05-13-09 Undated but date stamped pre-authorization request, unsigned
- o 05-15-09 Form DWC PLN 11
- o 05-18-09 Pre-authorization request form
- o 05-19-09 Adverse Determination Letter/Review from
- o 05-27-09 Adverse Determination Letter for reconsideration SI joint injections
- o 05-29-09 Request for IRO

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews the patient is a female who sustained an industrial injury to the low back and right foot on March 9, 2009 when she slipped and fell. Initial examination on the date of injury was significant only for some tenderness on the dorsum of the right foot, lumbar flexion to 80 degrees and extension to 10 degrees. Low back and foot radiographs were unremarkable. The patient was diagnosed with sprain injuries.

The patient was seen in follow-up on March 23, 2009. Normal lumbar flexion was demonstrated. Extension was limited to 10 degrees. The patient may continue to work full duties.

The patient was assessed in PT on March 24, 2009. She is using ibuprofen and a muscle relaxant. She is a who supervises kids. The patient reports persisting right low back pain that extends to the buttock with tingling in the right thigh and

calf. She reports a pain level ranging from 4-9/10. The neurologic exam is normal. She reports pins and needles across the S1 distribution. There is pain over the right L5-S1 facet and right SI joint. There is weakness in the S1 myotome. Lumbar flexion is 40/60 (per AMA guidelines) and extension 20/25. Provocative tests for radiculopathy are negative. There is increased pain with backward bend and SI joint gapping. Impression is SI joint sprain and symptoms of S1 radiculopathy.

On April 3, 2009 the patient was authorized 6 sessions of physical therapy.

The medical report of April 10, 2009 indicates the patient is reporting persisting low back pain. Examination is unremarkable with exception of lumbar extension restricted to 10 degrees. MRI is recommended. On April 20, 2009 moderate tenderness was noted in the right SI joint with a positive FABER. Extension and lateral bending are to 5 degrees. Diagnosis is lumbar sprain more likely than SI joint dysfunction.

Lumbar MRI was performed on April 24, 2009 and given impression of: Disc disease and spondylosis primarily at L5-S1 with asymmetry to a left annular bulge contributing to left foraminal stenosis. No canal stenosis is seen. Findings indicate, dessication and disc space narrowing at L5-S1 with asymmetric left annular bulging without focal compression, canal stenosis or foraminal stenosis.

On May 6, 2009 the provider noted right SI joint complaints, a benign MRI in regard to disc herniations. Gillet sign is positive for SI joint hypomobility and there is a positive FABER. Recommendation is for right SI joint injection.

Per a letter from the carrier dated May 15, 2009 the pre-existing degenerative changes seen on MRI are not accepted as part of the injury of March 3, 2009.

Request for right SI joint injection was not certified in review on May 19, 2009 with rationale that the type and quality of PT was not clarified, the medication management was not clarified and the rationale for proceeding to SI joint injection was not therefore substantiated. It is noted that the carrier accepts only the sprain injuries not the pre-existing degenerative changes.

Request for reconsideration for right SI joint injection was not certified in review on May 27, 2009 with rationale that attempt of oral steroid burst pack, the amount and type of PT applied, and a home exercise program have not been clarified. The disputed issue of pre-existing degenerative changes visualized on MRI were noted.

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

ODG supports SI joint injection as an option for patients who have failed at least 4-6 weeks of aggressive conservative therapy including PT, home exercise and medication management. Diagnostic evaluation must first address any other possible pain generators. The history and physical should suggest the diagnosis (with documentation of at least 3 positive exam findings as listed below).

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). 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.

The patient has only had 6 visits of PT. The patient's instruction and participation in self-directed home exercises have not been clarified. The diagnosis of SI joint pathology is difficult to determine and guidelines require documentation of at least 3 positive exam findings as noted in the paragraph above, which have not been documented. Given guideline recommendations, it does appear that it is premature to proceed to injection at this time. Therefore, my recommendation is to uphold the prior non-determination for right SI joint injection.

The IRO's decision is consistent with the following guidelines:

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

The Official Disability Guidelines, Low back (5-19-2009), Sacroiliac joint injections:

Recommended as an option if failed at least 4-6 weeks of aggressive conservative therapy. See the Hip & Pelvis Chapter for more information, references, and ODG Criteria for the use of sacroiliac blocks.

ODG, Hip and Pelvis (6-19-2009), Sacroiliac Joint Blocks:

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). 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.

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.

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.