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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient Right SI Joint RF Lesioning L5, S1, S2, S3 (64622, 64623, 96360, 77003)

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

MD, Board Certified in Physical Medicine and Rehabilitation
Subspecialty Board Certified in Pain Management
Subspecialty Board Certified in Electrodiagnostic Medicine

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

ODG Guidelines and Treatment Guidelines
Adverse Determination Letters, 7/27/09, 9/3/09
DO, 8/19/09, 7/20/09, 6/17/09, 5/27/09, 4/15/09, 3/18/09,
2/18/09, 1/21/09, 12/19/08, 12/3/08
MRI Lumbar Spine, 6/29/05
Operative Report, Right sacroiliac joint injection under fluoroscopic
guidance, 6/10/09
Lumbar ESI, 5/20/09, 1/14/09
Medical Centers, 11/4/08
Electrodiagnostics, 1/24/05
MRI Lumbar Spine, 9/9/03
Lumbar Myelogram and Post CT, 3/5/04, 12/1/04

PATIENT CLINICAL HISTORY SUMMARY

This is a male injured in xx/xx. He underwent 3 lumbar procedures including L4/5 and L5/S1 spinal fusion. The 2004 note describes a pseudoarthrosis. He has ongoing radicular and low back pain. Dr. was able to improve his radicular symptoms with an epidural steroid injection. A right SI injection provided about 2 months of relief per Dr.. She requested authorization for an rf rhizotomy of the right SI joint. I reviewed the material provided above. The examination described tenderness at the right SI region and pain with the FABER maneuver.

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

Dr. , DO, feels that the pain relief after the SI joint injection justifies the SI RF. There are several physical signs found with SI pain. Other studies show the low specificity of the studies. The more signs, the better the likelihood that the SI joint is causing the pain. Only the FABER sign was described in the provider's records since December 2008. It was abnormal. The ODG discusses the high incidence of false positive blocks in providing pain relief as not confirming the presence of SI pain.

The specific paragraph/section in the ODG places the SI RF as not recommended.

The American Society of Interventional Pain Physician Guidelines were published in Pain Physician 2007. (10:7-111) Page 53 discusses Radiofrequency Neurotomy of the SI joint. 6.4.2.2 "The evidence for thermal and pulsed radiofrequency neurotomy in managing sacroiliac joint pain is limited." While this does not mean there is no benefit from the procedure, the benefit has not been proven.

In order to diverge from the ODG Guidelines there needs to be evidence to justify a variance. This was not included in the records provided for this review. The reviewer finds that medical necessity does not exist at this time for Outpatient Right SI Joint RF Lesioning L5, S1, S2, S3 (64622, 64623, 96360, 77003).

Sacroiliac joint block

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). (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 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.

Sacroiliac joint radiofrequency neurotomy

Not recommended. Multiple techniques are currently described: (1) a bipolar system using radiofrequency probes (Ferrante, 2001); (2) sensory stimulation-guided sacral lateral branch radiofrequency neurotomy (Yin, W 2003); (3) lateral branch blocks (nerve blocks of the L4-5 primary dorsal rami and S1-S3 lateral branches) (Cohen, 2005); & (4) pulsed radiofrequency denervation (PRFD) of the medial branch of L4, the posterior rami of L5 and lateral branches of S1 and S2. (Vallejo, 2006) This latter study applied the technique to patients with confirmatory block diagnosis of SI joint pain that did not have long-term relief from these diagnostic injections (22 patients). There was no explanation of why pulsed radiofrequency denervation was successful when other conservative treatment was not. A > 50% reduction in VAS score was found for 16 of these patients with a mean duration of relief of 20 ± 5.7 weeks. The use of all of these techniques has been questioned, in part, due to the fact that the innervation of the SI joint remains unclear.

There is also controversy over the correct technique for radiofrequency denervation. A recent review of this intervention in a journal sponsored by the American Society of Interventional

Pain Physicians found that the evidence was limited for this procedure. (Hansen, 2007) See also Intra-articular steroid hip injection; & Sacroiliac joint blocks

Recent research: A small RCT concluded that there was preliminary evidence that S1-S3 lateral branch radiofrequency denervation may provide intermediate-term pain relief and functional benefit in selected patients with suspected sacroiliac joint pain. One, 3, and 6 months after the procedure, 11 (79%), 9 (64%), and 8 (57%) radiofrequency-treated patients experienced pain relief of 50% or greater and significant functional improvement. In contrast, only 2 patients (14%) in the placebo group experienced significant improvement at their 1-month follow-up, and none experienced benefit 3 months after the procedure. However, one year after treatment, only 2 patients (14%) in the treatment group continued to demonstrate persistent pain relief. Larger studies are needed to confirm these results and to determine the optimal candidates and treatment parameters for this poorly understood disorder. (Cohen, 2008)

The American Pain Society guidelines were summarized in Spine in May 2009 did not address this.

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

ACOEM-AMERICA 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)

The American Society of Interventional Pain Physician Guidelines, Pain Physician 2007. (10:7-111) Page 53; American Pain Society Guidelines, Spine, May 2009.