

MEDR X

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Notice of Independent Review Decision

DATE OF REVIEW: 10/27/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a Diagnostic Bilateral Sacroiliac Joint Injection (27096, 73542, and 77003).

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

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 agrees with the previous adverse determination regarding a Diagnostic Bilateral Sacroiliac Joint Injection (27096, 73542, and 77003).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:
MD, and Dr.

These records consist of the following (duplicate records are only listed from one source):
Records reviewed from , MD: Follow-up Evaluation Notes – 7/7/09-8/5/09, Request for

Reconsideration – 7/28/09; DWC69 – 12/19/07 & 5/27/08; Evaluation & Impairment Rating Report – 12/19/07 & 5/27/08; DWC73's; MD MRI report – 6/14/07.

Records reviewed I: Denial letter – 7/20/09 & 8/5/09; Pain Consultants Pre-Authorization request – 7/14/09 & 7/29/09.

Records reviewed – letter – 10/16/09.

Records reviewed from Dr. : Update Assessment/Physical Examination report – 11/27/07-8/5/09, Initial Assessment/Physical Examination report – 11/9/07, Out Patient Status Notes – 8/28/08; MD Follow-up Evaluation report – 7/15/08-11/17/08.

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient was injured when exiting a vehicle at work. She fell forward with her face hitting the ground. She was found to have fracture of the right orbit, lower back pain, right shoulder capsular tear, right wrist pain, and neck pain. She had referrals to several doctors, including Dr. who has served as Pain Management Consultant. Return to Work programs included completion of a work conditioning program and was able to RTW. Surgical treatment for the orbit fracture included placement of a plate. Dr. initially identified facet disease, but invasive treatment did not result in any lasting relief of the lower back area pain. Dr. currently wants to perform diagnostic bilateral SI Joint injections. Recent examination reports from Dr. indicate SI Joint exam to show “tenderness over the bilateral SI joints, left side greater than right.”

There is no mention of results of any of the following tests as mentioned in the ODG to determine medical necessity for the invasive procedure: 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).

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

According to the ODG: Diagnostic Bilateral Sacroiliac Joint Injections are recommended as an option if the patient has 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.

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.
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.

The ODG criteria for this procedure are clearly stated above. The documentation does not meet these standards; therefore, the procedure is not medically indicated at this time.

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)