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Notice of Independent Review Decision

MEDICAL RECORD REVIEW:

DATE OF REVIEW: 09/09/09

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

Bilateral SI joint injection with sedation

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 02-19-09 COPE program for evaluation from Dr.
- o 05-19-09 Follow-up report from PA-C for Dr.
- o 05-28-09 Follow-up report from Dr.
- o 06-02-09 Request for physical therapy, 6 visits from Dr.
- o 06-04-09 Follow-up report from Dr.
- o 06-09-09 Follow-up report from Dr.
- o 06-16-09 Follow-up report from Dr.
- o 06-18-09 Radiology report CT of sinuses read by Dr
- o 06-23-09 Follow-up report from Dr.
- o 07-09-09 Follow-up report from Dr.
- o 07-09-09 Script for bilateral SI joint injections from Dr.
- o 07-16-09 Letter of non-certification for request for SI joint injections
- o 07-22-09 Request for preauthorization for bilateral SI joint injection from Dr
- o 07-29-09 Adverse determination letter - non-certification of reconsideration for SI Joint injections
- o 08-12-09 Follow-up report from Dr.
- o 08-25-09 Request for IRO from Claimant
- o 08-25-09 Notice of IRO assignment

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews, the patient is a xx-year-old photographer who sustained an industrial injury to the head and face on xx/xx/xx when a camera fell on her hitting her eye and knocking her onto her back with loss of consciousness.

The patient was evaluated for participation in a COPE program on February 19, 2009. Since the injury the patient has had clear liquid coming out of her nose and may or may not be any better. She had an EMG and was told she has C7 radiculopathy. She is being managed chiropractically and is being seen also in pain management. She had a back MRI but does not recall ever having an MRI of her head. She has had cervical epidurals which she reports were helpful. She uses magnesium but no prescription medications. She reports right-sided neck pain and right scapular pain and some lumbar pain. She also reports numbness diffusely in the fingers. She does not smoke or drink. She desperately wants to get back to work. She is 5' 7" and 220 pounds. She is neurologically intact in the upper and lower extremities. She has cervical, thoracic and lumbar syndrome and an ethmoid fracture should be ruled out. Otherwise, she is cleared for the COPE program.

The patient was seen in follow-up on May 19, 2009. She has been treated for chronic neck pain. She also reports fracture to her skull with a chronic CSF leak. She reports headaches. She has started the COPE program this week.

The patient was reevaluated on May 28, 2009. She is having episodes of tearfulness and anxiety. She has had this in the past during a divorce and when depressed after a hysterectomy. Paxil will be tried. She continues to have headaches. There is a somewhat positive Spurling's on the right. Ultram will also be tried. She continues in the COPE program. On June 2, 2009 5 visits of PT were ordered.

At reevaluation on June 4, 2009 the patient brought her cervical, thoracic and lumbar MRI films. MRI of the lumbar spine appears to be normal. She has been having disturbing dreams and memory problems.

The patient was seen again on June 6, 2009. Paxil appears to be helping. She reports some blood in the nose fluid for the first time. It is hard to tell whether this is from the CSF or just postnasal drip. She will have a head CT.

At follow-up on June 16, 2009 the patient reported low back pain and tenderness over the SI joints. FABERE and Gaenslen's are positive. She continues in the COPE program. The low back clicks and bothers her when standing. The therapist will be asked to work also on her low back.

The medical report of June 23, 2009 notes the CT scan shows no ethmoid fracture. There is some sinusitis and a deviated septum. She is complaining of some SI dysfunction. She is using ice and heat and the therapist is addressing this complaint. She has an ENT referral pending.

The patient returned to her provider on July 9, 2009 for an impairment rating. She has completed the COPE program. Her injuries and diagnostic studies are reviewed. She has seen a chiropractor for her SI joint pain. On examination she has some diffuse tenderness in the lumbosacral area. Decreased sensation is noted in the left posterior lateral leg and sitting root test is slightly positive on the left. Motor strength and reflexes are normal. She has 30 degrees of lumbar flexion and 5 degrees of extension. Left lateral bending is to 20 degrees and right lateral bending to 10 degrees. She has a 5% impairment of the whole person for the cervical, thoracic and lumbar regions (total 15%). She still has some SI joint instability and an injection has been ordered for diagnostic and therapeutic purposes.

The patient was most recently reevaluated on August 12, 2009. She reports continuing neck pain, worse with lying down. She has daily diarrhea of unknown etiology. She is using Paxil and Ultram. She reports persisting low back pain and some numbness in the feet that is worse than prior. There is tenderness at both SI joints, right greater than left. She has a markedly positive Patrick maneuver bilaterally. Gaenslen's and Yeoman's tests are positive bilaterally. Stork test is positive, left greater than right. Recommendation is for bilateral sacroiliac joint injections for diagnostic and therapeutic purposes.

According to a non-certification letter dated July 16, 2009, request for bilateral SI joint injections was not certified in review with rationale that the requested services are not medically necessary. Per the reviewer, the medical reports lacked objective documentation such as radiographic or objective physical examination findings, or a series of reports to support the request. A per discussion was attempted but not realized.

Request for reconsideration for bilateral SI joint injections was not certified in review on July 29, 2009 with rationale that no objective evidence on examinations supporting focalized pain to the SI joints. No reported diagnostic studies were submitted supporting pathology to the SI joints. There was no specific clarification of HEP in terms of addressing focal SI joint regional pain. The guidelines do not support the request. A peer discussion was attempted but not realized.

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

The patient has been treated for almost two years for neck pain, upper back pain, headaches and sinus leakage following trauma to the head. She has completed a chronic pain program. 19 months post injury, (June 2009) the patient reported some low back symptoms. A prior MRI of the lumbar spine was noted to be normal. On June 16, 2009 she reports clicking at the low back with standing. On June 23, 2009 she complains of some SI joint symptoms. She is using ice and heat and the therapist is addressing this complaint, which is described as SI joint dysfunction. On July 9, 2009 it is noted the patient's chiropractor has addressed her SI joint pain. Presumably manipulation was provided to the lumbosacral and SI joints. On examination she has some diffuse tenderness in the lumbosacral area. Decreased sensation is noted in the left posterior lateral leg and sitting root test is slightly positive on the left. Motor strength and reflexes are normal. She has 30 degrees of lumbar flexion and 5 degrees of extension; left lateral bending is to 20 degrees and right lateral bending to 10 degrees. Without examination findings pertaining to the SI joint, the provider determines that she still has some SI joint instability and an injection has been ordered for diagnostic and

therapeutic purposes. SI joint instability, which would involve hypomobility, is not clarified as to right or left. On August 12, 2009 the patient reports, low back pain and some numbness in the feet that is worse than prior. Examination findings note, tenderness at both SI joints, right greater than left, a markedly positive Patrick maneuver bilaterally, positive Gaenslen's and Yeoman's tests bilaterally and a positive Stork test, left greater than right.

Per ODG, 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.

Orthopedic tests such as Yeoman's or Gaenslen's tests are not generally considered very reliable to diagnose SI joint dysfunction. There really is not a single non-invasive diagnostic test which is able to isolate the sacroiliac joint, and thus anesthetic injection blocks specifically applied to the joint could serve a diagnostic function.

ODG state that 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 (palpable tenderness caudal to the PSPS); 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 criteria for SI joint injections state, the history and physical should suggest the diagnosis (with documentation of at least 3 positive exam findings as listed above). The diagnostic evaluation must also first address any other possible pain generators. While three positive exam findings have been documented (Gaenslen's, Patrick and Stork), guidelines also state that SI joint injections can be considered only after aggressive therapy (at least six weeks of a comprehensive exercise program, local icing, mobilization/manipulation and anti-inflammatories) and when there is evidence of a clinical picture that is suggestive of sacroiliac injury and/or disease. The patient reportedly is being managed chiropractically. However, no chiropractic reports have been referenced. The patient has had some therapy (5 visits?) in which the therapist addressed the SI joint complaints, also without further clarification or submission of applicable reports.

ODG states the diagnostic evaluation must first address any other possible pain generators and, 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. The patient reports low back pain and some numbness in the feet that is worse than prior and clicking in the low back clicks when standing. While the patient reportedly has a normal lumbar MRI, examination findings note significant limited lumbar flexion, extension and right lateral bending, diffuse tenderness in the lumbosacral area, decreased sensation in the left posterior lateral leg and slightly positive left root sign, indicating ongoing lumbar pain generators not been fully addressed.

There is a paucity of documentation of this new problem in an overweight claimant 19 months post face and head injury. Given the patient is being managed chiropractically and is developing both low back pain, increasing numbness in the feet, and SI joint tenderness, the diagnosis of SI joint instability is not well established or addressed in the manner required by guidelines to meet the criteria for SI joint injections. Although five therapy visits are noted to have been provided, it does not appear that the patient has attended an aggressive course of conservative therapy directed to the SI joints with development of an active home exercise program.

Therefore, my recommendation is to agree with the previous non-certification for bilateral SI joint injection with sedation.

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 KNOWLEDGBASE

____ 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 - Hip and Pelvic Chapter (8-21-2009): Intra-articular Steroid Hip Injection:

Not recommended in early hip osteoarthritis (OA). Under study for moderately advanced or severe hip OA, but if used, should be in conjunction with fluoroscopic guidance. Intraarticular glucocorticoid injection with or without elimination of weight-bearing does not reduce the need for total hip arthroplasty in patients with rapidly destructive hip osteoarthritis.

ODG: Hip and Pelvic Chapter, (8-21-2009) Sacro-iliac 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). (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.

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.