

SENT VIA EMAIL OR FAX ON
Aug/11/2010

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Aug/10/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Bilateral Sacroiliac Injection and Injection Guidance

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

Board Certified Orthopedic Surgeon

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

OD Guidelines

Dr. office notes 06/01/10, 06/15/10, 06/22/10, 06/29/10, 07/13/10, 07/27/10

Pre auth request 06/02/10

Peer reviews 06/08/10, 06/23/10

Dr. record review 06/28/10

Dr. letter 06/29/10

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female with a reported low back injury on xx/xx/xx when she was moving. Records indicate that the claimant was evaluated by Dr. on 06/01/10, referred by Dr., chiropractor. The claimant had low back pain with no leg pain. MRI of the lumbar spine done on 5/25/10 (report not provided) was noted to show moderate size right sided herniated disc at L5-S1; small left sided intraforaminal disc protrusion at L3-4; small central disc protrusion at T11-12, degenerative disc disease and mild bulging of the annulus at L2-3. The claimant had a history of lumbar surgery in 2003 – left sided L5-S1 microdiscectomy. On exam of 06/01/10 the claimant had tenderness of the lumbar paraspinal musculature; percussion was positive from L3 to S1. Straight leg raise was negative. Reflexes were 2/4 and

strength was 5/5; sensation was intact. Bilateral sacroiliac joints were tender and the claimant had a positive Patrick's/Fabere test, positive Yeoman's test, and positive Gaenslen's test/maneuver. The diagnoses were low back pain, herniated disc/bulges L2-3, L3-4, L5-S1, T11-12, sacroiliac pain and sacroiliac disorder, sciatica, and arthropathy of the lumbar spine. The physician recommended physical therapy, Mobic, Ultram, Robaxin, Medrol Dosepak, and sacroiliac injections. EMG/NCS of the lower extremities was also ordered. A pre auth request dated 06/02/10 was for a bilateral sacroiliac injection with injection guidance.

Sacroiliac injections were denied on peer review. On 06/22/10 Dr. noted that the EMG/NCS on 06/17/10 showed evidence of peroneal mononeuropathy of uncertain etiology. Exam findings were unchanged. At that visit Dr. recommended lumbar epidural steroid injection. At the 06/29/10 visit Dr. again recommended epidural steroid injection. Exam findings at the visit of 07/13/10 were unchanged. The claimant was noted to be awaiting approval for epidural steroid injection. At the 07/27/10 visit the claimant complained of left foot numbness and paresthesias although exam findings were unchanged. The physician again recommended lumbar epidural steroid injection.

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

The physician has described some positive exam findings pertaining to sacroiliac joint dysfunction. However, he also discusses an L5-S1 disc herniation although there is no documentation of radicular pain or symptoms. The MRI report is not provided. At the initial visits of xx/xx/xx and 06/15/10 Dr. recommended sacroiliac injections. However it appears that since 06/22/10 he is requesting an epidural steroid injection. There is no further discussion in his notes regarding sacroiliac injections. Dr. clearly states in his last four office visits that the claimant is awaiting authorization for epidural steroid injection. The sacroiliac injections are not recommended as it is unclear that the current clinical picture is suggestive of sacroiliac injury and/or disease and there are confounding factors of L5-S1 disc herniation and the fact that it appears that a sacroiliac injection is no longer part of the treatment plan. Therefore, based on the information provided, the sacroiliac injection is not recommended as medically necessary.

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2010 Updates. Hip and Pelvis: 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). ([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](#).

Recent research: A systematic review commissioned by the American Pain Society (APS) and conducted at the Oregon Evidence-Based Practice Center states that there is insufficient evidence to evaluate validity or utility of diagnostic sacroiliac joint block, and that there is insufficient evidence to adequately evaluate benefits of sacroiliac joint steroid injection. ([Chou, 2009](#))

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.
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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)