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Notice of Independent Review Decision

DATE OF REVIEW: December 7, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Injection procedure for sacroiliac joint, arthrography and/or anesthetic/steroid

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

The physician providing this review is a Doctor of Medicine (M.D.). The reviewer is national board certified in Physical Medicine and Rehabilitation as well as Pain Medicine. The reviewer is a member of International Spinal Intervention Society and American Medical Association.

REVIEW OUTCOME

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

Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Diagnostics (01/22/09)
- Procedure (01/14/10)
- Office Visits (01/29/10 – 09/13/10)
- Utilization reviews (09/21/10 – 11/17/10)

Dr.

Procedure Notes (05/14/09 – 01/14/10)

- Office visits (05/19/08 – 11/08/10)

TDI

- Utilization reviews (10/27/10 – 11/18/10)

ODG has been utilized for the denials.

The patient is a female who sustained a work-related injury on xx/xx/xx, when she bent over to pick up some heavy boxes and experienced severe pain in her lower back.

1997 – 2007: No records are available.

On May 19, 2008, the patient was evaluated by M.D., for complaints of low back pain and numbness. Dr. noted: *“Following the injury, the patient was in the hospital for eight days and was treated conservatively. In August 2007, she underwent a laminectomy by Dr.. She continued to have pain and was referred to a pain specialist who did numerous back injections. For persistent low back pain, eventually the patient consulted Dr. who did a fusion in 1998. The fusion did not really help much. The patient had refusion at L4-L5 in April 2000 by Dr.. Because of the unremitting nature of pain, the patient consulted Dr. who ordered physical therapy (PT) and placed a spinal cord stimulator (SCS) which seem to be covering her right leg adequately. The patient also had facet injections and radiofrequency thermocoagulation (RFTC) lesioning to her sacroiliac (SI) joints after diagnostic SI joints injections which seemed to relieve her pain. Dr. requested caudal epidural steroid injection (ESI) with Racz catheter and adhesiolysis which was turned down by the insurance company. On February 28, 2003, the patient underwent a disability evaluation by Dr. who opined that the therapies given were in line with injury sustained on xx/xx/xx, but further spine injections were not indicated and the patient was not a candidate for continuing psychological management and instead a good home exercise program with anti-inflammatories would be more than appropriate. The patient was also treated by numerous other physicians including Dr. PMR, as well as Dr., a spine surgeon. She had been through two of the multidisciplinary chronic pain programs in 1998 and the other one in 2002.”* The patient now complained of severe low back and right leg pain radiating all the way down to the leg from the buttocks down into the feet and also severe pain over the SI joints. The pain in the SI joint had been relieved by the SI joint injections and RFTC in the past. X-rays of the lumbar spine performed in 2006 revealed an interbody cage at L4-L5 with a posterior spinal fusion and two interbody cages at L5-S1 with an apparent stable fusion. The lumbar myelogram performed in 2006 showed no clumping of nodes that would be in line with an arachnoiditis. The electromyography/nerve conduction velocity (EMG/NCV) study of the lower extremities was unremarkable. On examination, there was complete loss of normal lumbar lordosis. There was marked tenderness over the SI joints, right worse than the left. Range of motion (ROM) of the lumbar spine was guarded and Patrick’s test was positive on the right. Dr. diagnosed lumbar back pain; prescribed Qualaquin, amitriptyline HCL, Norco, Lyrica and Robaxin and requested further diagnostic studies.

A lumbar myelogram and post-myelogram computerized tomography (CT) was performed in 2009; it revealed: (1) Postoperative changes at L4-L5-S1 with no evidence of spinal stenosis. (2) Disc bulging and facet hypertrophic changes mildly compressing the thecal sac at L2-L3. (3) Disc bulging and hypertrophic facet changes compressing the thecal sac resulting in spinal and foraminal narrowing at L3-L4.

Dr. performed a corticosteroid injection at L5-S1 in November 2009 and into the SI joints bilaterally on January 2, 2010. He noted reduction of pain by 55% with better functioning and utilizing less medication.

In March 2010, Dr. noted the patient was very depressed and was recently diagnosed with Parkinson’s disease. She was on appropriate antiparkinsonian

therapy and was doing well. Dr. prescribed Lidoderm patches in addition to previously prescribed medications and recommended behavioral therapy. But the patient denied behavioral therapy. In June, the patient presented to Dr. with bilateral SI joint pain. Examination revealed positive modified Patrick FABERE test for SI joint pain bilaterally. Dr. assessed SI joint dysfunction and recommended an SI joint block and refilled medications.

On September 21, 2010, M.D., denied the request for the SI joint block with the following rationale: *“There was lack of medical necessity for this request in accordance with the official disability guidelines (ODG) and the patient did not obtain 70% pain relief for at least six weeks after the previous injection. Therefore repeat injection would not be warranted at this time.”*

On October 27, 2010, D.O., denied the request for right SI joint injection with the following rationale: *“I have not determined the medical necessity of this request due to the available information and evidence-based guidelines. There was no indication from the available documentation/information that the first SI joint injection provided significant pain relief as 55% pain relief that was reportedly mentioned is not enough to justify the need for the repeat injection. There was also no documentation that at least three positive objective findings are present that support the diagnosis of the right SI joint dysfunction, based on the guidelines.”*

On November 8, 2010, Dr. placed an appeal for the same stating that there was exquisite tenderness over the SI joint areas bilaterally and Patrick’s, Faber’s, and Gaenslen’s were strongly positive bilaterally.

On November 17, 2010, Dr. upheld the denial with a following rationale: *“I have not determined the medical necessity of this request per a submitted document and evidence based guidelines. The ODG states regarding SI joint injections, criteria 6: “If steroids are injected during the initial injection, the duration of pain relief should be at least six weeks with at least greater than or equal to 70% pain relief recorded for this period.” In this situation the patient only had 55% relief, which does not meet the criteria for the ODG for a repeat injection.”*

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

Patient previously had denervation of SIJ and less than 70% relief of pain following SIJ injection. There is no evidence continuing this treatment would be effective or has the ability to be potentially effective, based on a denervated joint.

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

- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**