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Notice of Independent Review Decision

DATE OF REVIEW: 2/18/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

SI Joint Injection x3

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

Certified by the American Board of Anesthesiology with subspecialty certification in Pain Medicine

REVIEW OUTCOME

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

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Service Units	Upheld/ Overturned
		Prospective	724.4	20610	3	Upheld
		Prospective	724.4	099SG	3	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Correspondence throughout appeal process, including first and second level decision letters, reviews, letters and requests for reconsideration, and request for review by an independent review organization.

Physicians’/practitioner notes from 6/4/08 through 6/18/09

Examination/evaluation dated 12/4/08, 1/16/09

Operative reports dated 6/6/08, 7/28/09

X-ray report dated 12/12/08

Official Disability Guidelines cited - Hip and Pelvis: SI joint injection

PATIENT CLINICAL HISTORY:

The patient is a male who is reported to have sustained an injury to his low back on xx/xx/xx. He is reported to have twisted his low back resulting in pain in the low back and pre sacral area with radicular pain at the left lower extremity. This patient’s history also includes a non work related MVA occurring on 04/13/07. Records indicate that the patient was involved in a 3 car collision sustaining injuries to his low back and subsequently received treatment which included oral medications and lumbar ESIs. The patient subsequently came under the care of another treating provider for his work related low back pain with radicular symptoms. The clinical history indicates that the patient had a non work related ESI on 06/06/08 which is reported to have provided good results and resolved the patient’s low back pain. A second lumbar ESI was performed on 08/11/08 in relation to the work related injury and it is reported that this completely resolved the symptoms in the left lower extremity. An RME examination performed on 12/04/08 reports that the patient is 70 inches tall, weighs 184 pounds. He has an exaggerated biomechanical gait without discernable consistent antalgic component. He has tenderness which is inconsistent in the lumbar paralumbar

area. He has no sciatic tenderness, no spasm. Range of motion of the lumbar spine is reduced. DTRs are 3+ and symmetric and motor strength is graded as 5/5. Sensory is intact. Straight leg raise is reported to be negative.

MRI lumbar spine was performed on 12/12/08. This was compared against a previous MRI dated 01/28/08. This study reports small hemangiomas in the T12 and L2 vertebral bodies and there is no evidence of fracture. The L1-2 and L3-4 discs are reported to be normal. L2-3 disc is reported to be mildly narrowed with desiccation and there is a broad based annular bulge slightly flattening the anterior surface of the thecal sac. At L4-5 the disc is mildly narrowed with dehydration and there is a broad central protrusion of disc material which indents the anterior surface of the thecal sac. There continues to be potential for displacement of the L5 nerve roots as they separate from the thecal sac and there is mild left foraminal encroachment noted as well. At L5-S1 the disc is mildly narrowed with dehydration and there is a right paracentral protrusion of disc material once again largely contained within the anterior extradural fat. It is reported that the patient has a stable pattern of disc degeneration and annular bulging at L2-3, L4-5 and L5-S1 with central canal narrowing most advanced at L4-5. There is no disc herniation or adverse change since 01/28/08.

The patient continued under the care of his treating provider, receiving oral medications.

A designated doctor examination was performed on 01/16/09. At this time, it is reported that the patient was carrying a box full of auto parts into a garage on 06/03/08 when he slipped on a puddle of spilled oil. He went through contortions and movements trying to keep himself from falling and ended up twisting his back. It was opined that the examinee is not at MMI. These records indicate that the patient had received conservative treatment which included chronic use of oral medications and 2 lumbar ESIs. On physical examination the patient is 5'10" tall and weighs 175 pounds. He was with an antalgic gait. He arises with care from a seated position. On physical examination there are no surgical scars and percussion produced no guarding or muscle spasms. Straight leg raise was negative at 90 degrees bilaterally. In a standing position, deep palpation of the right and left sciatic notches produced exquisite and a reproduction of his pain in a consistent manner, left greater than right opined to be diagnostic for sacroiliac dysfunction. His reflexes were 2+ and symmetric and his motor strength was graded as 5/5. He is reported to have decreased sensation between the first and second toes on the left foot, opined to be indicative of a sensory radiculopathy at L5 on the left. It is reported that the examinee has no indication of lumbar radiculopathy and that the patient has age related degenerative disease throughout the lumbar spine. He opines that the examination strongly suggests severe sacroiliacitis and recommends that the patient undergo sacroiliac injections.

Records report that the patient apparently had medial branch blocks on the left which were reported to be effective. A clinic note dated 03/25/09 indicates that the patient ran out of his medications 9 days early and would like a left sacroiliac joint injection. He apparently had sacroiliac joint manipulation which increased his low back pain. The submitted clinical records do not contain any serial physical examinations. It appears that the patient underwent a left sacroiliac joint injection on 05/28/09 which is reported to help his local pain in his buttocks. He subsequently was recommended to undergo a lumbar ESI on 06/18/09. The record contains an operative report dated 07/28/09 which indicates that the patient underwent lumbar medial branch blocks bilaterally from L3-S1. A request was placed for sacroiliac joint injection x3.

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

The Reviewer noted that the submitted clinical records indicate that the patient has a history of chronic low back pain pre dating the work place event of 06/03/08. The patient has previously been

treated with lumbar ESIs, facet joint blocks, medial branch blocks, and there is a suggestion of a left SI joint injection performed on 05/28/09. The submitted clinical records do not contain any detailed physical examination findings and largely contain subjective information. These records do not provide any physical examination findings that are consistent with a diagnosis of sacroiliac joint dysfunction. It is further noted that the patient has undergone MRI of the lumbar spine which shows multi level degenerative changes without indication of pathology regarding the sacroiliac joints. The record does not include any plain radiographic reports evaluating the sacroiliac joints.

In the Reviewer's opinion, there is insufficient objective information to establish that the patient has a sacroiliacitis and therefore the requested sacroiliac joint injections are not supported by ODG or ASIPP treatment guidelines.

References:

The 2010 Official Disability Guidelines, 15th edition, The Work Loss Data Institute. Online edition.

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.

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 FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)