

INDEPENDENT REVIEWERS OF TEXAS, INC.

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Notice of Independent Review Decision

DATE OF REVIEW: 09/01/10

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Sacroiliac injection, fluoroscopy 27096

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

Texas Board Certified Physical Medicine & Rehabilitation

Texas Board Certified Pain Management

REVIEW OUTCOME

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

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. 11/10/07 - Clinical Note - Unspecified Provider
2. 11/16/07 - Clinical Note - Unspecified Provider
3. 11/21/07 - Physical Therapy Notes
4. 11/23/07 - Clinical Note - Unspecified Provider
5. 11/30/07 - Clinical Note - Unspecified Provider
6. 01/31/08 - MRI Lumbar Spine
7. 02/19/08 - Clinical Note - DO
8. 03/12/08 - Functional Capacity Evaluation
9. 05/05/08 - Functional Capacity Evaluation
10. 05/19/08 - Designated Doctor Evaluation
11. 07/18/08 - Clinical Note - Unspecified Provider
12. 07/30/08 - Chiropractic Therapy Notes -, DC
13. 08/01/08 - Chiropractic Therapy Notes -, DC
14. 08/08/08 - Chiropractic Therapy Notes -, DC
15. 08/11/08 - Chiropractic Therapy Notes -, DC
16. 08/15/08 - Chiropractic Therapy Notes -, DC
17. 08/22/08 - Chiropractic Therapy Notes -, DC
18. 08/27/08 - Chiropractic Therapy Notes -, DC
19. 08/29/08 - Chiropractic Therapy Notes -, DC

20.09/02/08 - Chiropractic Therapy Notes -, DC
21.09/03/08 - Chiropractic Therapy Notes -, DC
22.09/09/08 - Chiropractic Therapy Notes -, DC
23.09/10/08 - CT Lumbar Myelogram
24.09/15/08 - Chiropractic Therapy Notes -, DC
25.09/16/08 - Chiropractic Therapy Notes -, DC
26.09/18/08 - Chiropractic Therapy Notes - DC
27.09/23/08 - Chiropractic Therapy Notes -, DC
28.09/25/08 - Chiropractic Therapy Notes - DC
29.10/08/08 - Chiropractic Therapy Notes -, DC
30.10/14/08 - Chiropractic Therapy Notes -, DC
31.10/16/08 - Chiropractic Therapy Notes -, DC
32.10/20/08 - Chiropractic Therapy Notes -, DC
33.10/22/08 - Chiropractic Therapy Notes -, DC
34.10/24/08 - Chiropractic Therapy Notes - DC
35.10/27/08 - Chiropractic Therapy Notes -, DC
36.10/29/08 - Chiropractic Therapy Notes -, DC
37.10/30/08 - Chiropractic Therapy Notes -, DC
38.10/31/08 - Chiropractic Therapy Notes -, DC
39.11/03/08 - Chiropractic Therapy Notes - , DC
40.11/05/08 - Chiropractic Therapy Notes -, DC
41.11/06/08 - Chiropractic Therapy Notes -, DC
42.11/10/08 - Chiropractic Therapy Notes -, DC
43.11/13/08 - Chiropractic Therapy Notes -, DC
44.11/17/08 - Chiropractic Therapy Notes -, DC
45.11/19/08 - Chiropractic Therapy Notes -, DC
46.11/24/08 - Chiropractic Therapy Notes -, DC
47.11/25/08 - Chiropractic Therapy Notes -, DC
48.12/01/08 - Chiropractic Therapy Notes -, DC
49.12/02/08 - Chiropractic Therapy Notes - DC
50.12/03/08 - Chiropractic Therapy Notes -, DC
51.12/04/08 - Chiropractic Therapy Notes -, DC
52.12/08/08 - Chiropractic Therapy Notes -, DC
53.12/09/08 - Chiropractic Therapy Notes -, DC
54.12/10/08 - Chiropractic Therapy Notes -, DC
55.12/11/08 - Chiropractic Therapy Notes -, DC
56.12/15/08 - Chiropractic Therapy Notes -, DC
57.12/17/08 - Chiropractic Therapy Notes -, DC
58.01/06/09 - Chiropractic Therapy Notes -, DC
59.01/13/09 - Chiropractic Therapy Notes -, DC
60.02/26/09 - Chiropractic Therapy Notes -, DC
61.03/16/09 - Chiropractic Therapy Notes - , DC
62.04/07/09 - MRI Lumbar Spine
63.04/16/09 - Chiropractic Therapy Notes -, DC
64.04/23/09 - Chiropractic Therapy Notes -, DC
65.04/30/09 - Chiropractic Therapy Notes -, DC

- 66.05/07/09 - Chiropractic Therapy Notes -, DC
- 67.05/14/09 - Chiropractic Therapy Notes -, DC
- 68.05/21/09 - Chiropractic Therapy Notes -, DC
- 69.05/28/09 - Chiropractic Therapy Notes -, DC
- 70.06/04/09 - Chiropractic Therapy Notes -, DC
- 71.06/11/09 - Chiropractic Therapy Notes -, DC
- 72.09/24/09 - Designated Doctor Evaluation
- 73.10/06/09 - Clinical Note -, MD
- 74.10/19/09 - Report of Medical Evaluation
- 75.11/04/09 - Mental Health Evaluation
- 76.12/01/09 - History and Physical
- 77.12/01/09 - Operative Report
- 78.12/01/09 - CT Lumbar Spine
- 79.12/07/09 - Clinical Note -, MD
- 80.12/20/09 - Operative Report
- 81.01/18/10 - Clinical Note -, MD
- 82.02/22/10 - Clinical Note -, MD
- 83.02/23/10 - Radiographs Bilateral Hips
- 84.06/04/10 - Letter -, MD
- 85.06/24/10 - Electrodiagnostic Studies
- 86.07/05/10 - MRI Lumbar Spine
- 87.07/19/10 - CT Pelvis
- 89. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a male who sustained an injury on xx/xx/xx when he lifted some heavy equipment and felt a “lightning bolt” in the right inguinal region.

The employee saw an unspecified provider on 11/10/07 with complaints of back pain and abdominal pain. Physical examination revealed mild tenderness to the abdomen and low back. There was full range of motion of the back. The employee was assessed with lumbar sprain/strain and abdominal sprain/strain. The employee was prescribed ibuprofen 600mg.

The employee was seen for evaluation on 11/30/07. The employee complained of low back pain that radiated to the right leg. Physical examination revealed mild tenderness and muscle spasm. The employee ambulated with a mild antalgic gait. Straight leg raise was positive on the right at 23 degrees. The employee was assessed with lumbar pain and muscle spasm. The employee was advised to use heat and rest.

An MRI of the lumbar spine performed 01/31/08 demonstrated no evidence of a lumbar disc herniation or nerve root compression. At L2-L3, there was a very mild 1 mm generalized disc bulge. At L3-L4, there was mild endplate spurring. There was no disc herniation or disc bulging. There was no lumbar compression or spondylolisthesis.

The employee attended fifty-eight chiropractic therapy sessions from 07/30/08 to 06/11/09.

A CT myelogram of the lumbar spine performed 09/10/08 demonstrated a mild disc bulge at L2-L3, which mildly impinges upon the thecal sac. There was also mild narrowing of the lateral recesses in both foramina at this segment. There were mild anterior extradural defects at L2-L3. There was markedly limited range of motion with lumbar flexion and extension, likely from surrounding paraspinous levels.

An MRI of the lumbar spine performed 04/07/09 demonstrated minimal disc desiccation from L2-L3 through L4-L5. Anterior fatty L3-L4 and left edematous L2-3 endplate degenerative changes were seen. No focal disc protrusion was seen, compromising the canal or nerves. A minimal disc bulge was seen at L2-L3.

A Designated Doctor Evaluation was performed on 09/24/09. The employee complained of low back pain. There was also numbness in the low back and tingling in the right leg. The employee rated the pain at 6 out of 10 on the visual analog scale. Current medications included Tylenol. Physical examination revealed tenderness at L3-S1 bilaterally. Palpation of the paravertebral muscles revealed spasms at L3-S1 bilaterally. Straight leg raise was to 30 degrees bilaterally and lumbar range of motion was decreased with full effort. There was pain with range of motion and the employee was able to performed toe and heel walk without difficulty. The employee was placed at Maximum Medical Improvement (MMI) and was assigned a 5% whole person impairment.

History and physical dated 12/01/09 stated the employee complains of low back pain that radiated to the right hip. The pain also radiated into the right L4 dermatome in the anterior aspect of the leg. The employee reported numbness in the big toes of both feet. The employee also reported numbness and tingling in the right leg. The employee rated the pain at 7 to 8 out of 10 on the visual analog scale. The employee denied bowel or bladder incontinence. Physical examination revealed no lumbar facet tenderness. There was pain with backward extension. There was no sacroiliac tenderness. Sensory examination to touch and pinprick indicated partial decreased sensation in the L4 dermatome in the right leg. The employee was assessed with possible discogenic chronic low back pain with right lumbar radiculitis. The employee was recommended for diagnostic discogram of the lumbar spine.

The employee underwent diagnostic discogram at L2-L3, L3-L4, L4-L5, and L5-S1 on 12/01/09. The discogram was unremarkable without any evidence of discogenic pain. A CT of the lumbar spine performed 12/01/09 demonstrated no evidence of significant herniation or protrusion following discograms at L2-L3 through L5-S1.

The employee saw Dr. on 12/07/09 with complaints of low back pain that radiated to the hips. The employee rated the pain at 7 to 8 out of 10. The pain worsened with physical activity. The physical examination revealed lumbar facet tenderness, more pronounced around L4-L5 and L5-S1. The lower extremity sensory examination to touch and pinprick indicated numbness, especially in the bottom of the foot. Straight leg raise testing was negative. The employee was assessed with lumbar facet arthropathy with chronic low back pain. The employee was recommended for diagnostic medial branch block or facet injections.

The employee underwent bilateral diagnostic and therapeutic lumbar facet injections at L4-L5 and L5-S1 on 12/29/09.

The employee saw Dr. on 01/18/10 with complaints of low back pain radiating in the front and the groin. The employee rated the pain at 7 to 8 out of 10 on the visual analog scale. The physical examination revealed no facet tenderness. Range of motion was decreased. Backward extension was painful. Internal and external rotation of the hip joint was painful. The employee was assessed with chronic low back pain. The employee was recommended for MRI of the pelvis.

The employee saw Dr. on 02/22/10 with complaints of low back pain radiating in the hips and in the inguinal area. The employee also reported numbness and tingling in the right leg. The physical examination revealed localized facet tenderness. Range of motion was decreased. Straight leg raise was positive on the right. The employee was assessed with right L4-L5 radiculopathy with chronic back pain. The employee was recommended for radiographs of the hips. If no fracture was seen, the employee would be recommended for right L4-L5 sleeve root injection. The employee was prescribed Lyrica.

Radiographs of the bilateral hips performed 02/23/10 demonstrated no evidence of acute osseous injury or significant degenerative changes.

Electrodiagnostic studies performed 06/24/10 demonstrated no electrical evidence for a lumbar radiculopathy or myelopathy. There was no electrical evidence for any mono or poly neuropathy involving the left lower extremity.

An MRI of the lumbar spine performed 07/05/10 demonstrated anterior endplate spondylosis at L2-L3, L3-L4, and L4-L5 with modic Type I-Type II degenerative marrow signal changes within the endplates of L3-L4 and L4-L5. There was facet joint effusion bilaterally at L3-L4 and L4-L5. There was slight facet asymmetry at L5-S1. There was no evidence of disc herniation or foraminal stenosis at any lumbar level. There was no evidence of post-contrast enhancing intraspinal, spinal, or paraspinal lesions.

A CT of the pelvis performed 07/19/10 demonstrated sacroiliac osteoarthritis with subchondral sclerosis and mild spurring.

The request for sacroiliac injection, fluoroscopy was denied by utilization review on 07/27/10 as the described symptoms were not consistent with a sacroiliac joint mediated pain syndrome.

The request for sacroiliac injection, fluoroscopy was denied by utilization review on 08/10/10 due to no documentation supporting the signs and symptoms of sacroiliac dysfunction. Per **Official Disability Guidelines**, there should be at least three signs on examination to decide whether the claimant has a diagnosis of sacroiliac joint dysfunction.

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

The clinical documentation does not support the request for sacroiliac joint injections with fluoroscopy. The employee has complaints of primarily low back pain with facet tenderness. Imaging of the hips and pelvis are fairly unremarkable. The physical examinations provided for review fail to demonstrate any significant findings that are consistent with sacroiliac joint dysfunction. Current evidence based guidelines recommend that employees have objective evidence of sacroiliac joint dysfunction in order to consider sacroiliac joint injections.

As there was no evidence on examination of any positive testing for sacroiliac joint dysfunction, the requested sacroiliac joint injections are not indicated and therefore not medically necessary.

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

1. **Official Disability Guidelines**, Online Version, Hip & Pelvis Chapter