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Notice of Independent Review Decision

DATE OF REVIEW: 12/5/11

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Appeal Right SI Joint, MBNB Right S1 S2 S3 64493 64494 64495

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

Board Certified Orthopaedic Surgeon

REVIEW OUTCOME

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

Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Clinical notes dated 11/30/2007 through 10/06/2011
2. An operative report dated 10/04/2007, 11/06/2008, 11/13/2009, and 03/25/2011
3. Therapy notes dated 09/16/2008 through 09/22/2008.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient is male who sustained an injury to his low back. The operative report dated 10/04/2007 details the patient undergoing a left-sided SI joint injection.

The clinical note dated 11/30/2007 details the patient reporting complete relief of his left-sided low back pain following SI joint injection. However, the patient described a right-sided pain at onset. The note details the patient undergoing a ligament injection at the L5-S1 level.

The operative report dated 11/06/2008 details the patient undergoing a right-sided sacroiliac joint injection as well as a right-sided iliolumbar ligament sclerosing procedure. The clinical note dated 02/05/2009 details the patient reporting persistent right buttocks and low back pain. The note does detail the patient having consistent

responses to several iliolumbar ligament injections lasting approximately 1 to 2 weeks each time. The patient, at that time, was utilizing Hydrocodone with good benefit.

The clinical note dated 03/02/2009 details the patient complaining of low back pain that he rated 5/10 at that time.

The operative report dated 11/13/2009 details the patient undergoing a right-sided L3, L4, L5 and S1 medial branch block.

The clinical note dated 11/19/2009 details the patient reporting initial analgesia following the diagnostic medial branch blocks. The patient stated that the pain had partially returned 1 week following the procedure. The patient also stated that the pain was gradually increasing.

The procedural note dated 01/26/2010, details the patient undergoing a right-sided L3, L4, L5, S1 medial branch block.

The clinical note dated 03/03/2010 details the patient describing intermittent right lateral leg pain extending to the calf and distally to the lateral malleolus.

The clinical note dated 03/31/2010 details the patient complaining of right buttocks pain that was radiating to the right calf and lateral foot.

The operative report dated 03/25/2011 details the patient undergoing a right sacroiliac joint injection.

The clinical note dated 04/27/2011 details the patient having 2 weeks of relief from pain following the SI joint injection. However, the patient stated that he has pain localized to the right buttocks, specifically with extension to the proximal, but not distal leg. The patient stated that the pain is exacerbated with prolonged standing and walking.

The clinical note dated 10/06/2011 details the patient complaining of right-sided buttocks pain. The patient described the pain as a deep and sharp sensation. The patient was noted to have previously received temporary benefit from the SI joint injection. The patient described increasing pain requiring increase in medications. The patient was noted to have a positive Patrick's, Yeoman's, Gaenslen's test and stress sign. Palpable tenderness was noted over the right sacroiliac joint.

The utilization review dated 10/21/2011 details a denial for S1, S2 and S3 branch blocks and an SI joint radiofrequency neurotomy as evidence based guidelines do not specifically recommend these procedures. The utilization review dated 11/01/2011 details a denial for a right-sided sacroiliac joint and right S1, S2 and S3 medial branch blocks, secondary to guidelines not recommending these procedures.

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

The request for a right-sided SI Joint, MBNB Right S1, S2 and S3 64493, 64494 and 94495 is non-certified. The documentation details the patient complaining of low back pain with radiation of pain to the right buttocks. The **Official Disability Guidelines** does not specifically recommend SI lateral branch blocks or ablation. The lateral branch block is a diagnostic procedure used in the sacral region; however, the subsequent procedure, a radiofrequency ablation, is not recommended by guidelines. As there is a lack of a recommendation regarding the subsequent procedure, the diagnostic procedure is thus not supported. Given the lack of certification, this request does not meet guideline recommendations. As such, the documentation submitted for this review does not support the request at this time.

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

REFERENCES: Official Disability Guidelines, Low Back Chapter, Online Version.
Sacroiliac joint radiofrequency neurotomy

Not recommended. Multiple techniques are currently described: (1) a bipolar system using radiofrequency probes (Ferrante, 2001); (2) sensory stimulation-guided sacral lateral branch radiofrequency neurotomy (Yin, W 2003); (3) lateral branch blocks (nerve blocks of the L4-5 primary dorsal rami and S1-S3 lateral branches) (Cohen, 2005); & (4) pulsed radiofrequency denervation (PRFD) of the medial branch of L4, the posterior rami of L5 and lateral branches of S1 and S2. (Vallejo, 2006) This latter study applied the technique to patients with confirmatory block diagnosis of SI joint pain that did not have long-term relief from these diagnostic injections (22 patients). There was no explanation of why pulsed radiofrequency denervation was successful when other conservative treatment was not. A > 50% reduction in VAS score was found for 16 of these patients with a mean duration of relief of 20 ± 5.7 weeks. The use of all of these techniques has been questioned, in part, due to the fact that the innervation of the SI joint remains unclear. There is also controversy over the correct technique for radiofrequency denervation. A recent review of this intervention in a journal sponsored by the American Society of Interventional Pain Physicians found that the evidence was limited for this procedure. (Hansen, 2007) See also Intra-articular steroid hip injection; & Sacroiliac joint blocks.

Recent research: A small RCT concluded that there was preliminary evidence that S1-S3 lateral branch radiofrequency denervation may provide intermediate-

term pain relief and functional benefit in selected patients with suspected sacroiliac joint pain. One, 3, and 6 months after the procedure, 11 (79%), 9 (64%), and 8 (57%) radiofrequency-treated patients experienced pain relief of 50% or greater and significant functional improvement. In contrast, only 2

patients (14%) in the placebo group experienced significant improvement at their 1-month follow-up, and none experienced benefit 3 months after the procedure. However, one year after treatment, only 2 patients (14%) in the treatment group continued to demonstrate persistent pain relief. Larger studies are needed to confirm these results and to determine the optimal candidates and treatment parameters for this poorly understood disorder. (Cohen, 2008)

Facet joint diagnostic blocks (injections)

Criteria for the use of diagnostic blocks for facet “mediated” pain:

Clinical presentation should be consistent with facet joint pain, signs & symptoms.

1. One set of diagnostic medial branch blocks is required with a response of $\geq 70\%$. The pain response should last at least 2 hours for Lidocaine.
2. Limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally.
3. There is documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks.
4. No more than 2 facet joint levels are injected in one session (see above for medial branch block levels).
5. Recommended volume of no more than 0.5 cc of injectate is given to each joint.
6. No pain medication from home should be taken for at least 4 hours prior to the diagnostic block and for 4 to 6 hours afterward.
7. Opioids should not be given as a “sedative” during the procedure.
8. The use of IV sedation (including other agents such as midazolam) may be grounds to negate the results of a diagnostic block, and should only be given in cases of extreme anxiety.
9. The patient should document pain relief with an instrument such as a VAS scale, emphasizing the importance of recording the maximum pain relief and maximum duration of pain. The patient should also keep medication use and activity logs to support subjective reports of better pain control.
10. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated. (Resnick, 2005)
11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. [Exclusion Criteria that would require UR physician review: Previous fusion at the targeted level. (Franklin, 2008)]