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Notice of Independent Review Decision

MEDICAL RECORD REVIEW:

DATE OF REVIEW: 12/20/2010

IRO CASE #:

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

This case was reviewed by a Pain Management (Board Certified) Doctor, Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient left sacroiliac joint injection

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be: Upheld (Agree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews the patient is a female employee who sustained an industrial injury to the abdomen, chest and low back on xx/xx/xx when pushed in the abdomen and chest by a. History includes some compression deformity at T11-T12 from a MVA and disc disease at L4-5. The patient is 5' 8" and 145 pounds. Co-morbid conditions include history of a left axillary mass removal in 1992, tubal ligation in 1994, polypectomy in 1993, and liver cirrhosis and splenomegally. Treatment has included PT with modalities, medications including Oxycodone, Fentanyl patches, Lyrica, Mobic and Meloxicam, two lumbar epidural injections. The patient was deemed MMI per DD opinions.

It is noted that the pain management specialist sees the patient both for the pre-existing abdominal pain and for the industrial injury complaints.

Per a pain management report of May 18, 2006 the patient was worked up for epigastric pain in her left upper quadrant and was found to have developed idiopathic liver dysfunction. She developed cirrhosis and has an enlarged spleen. She uses Oxycontin and Fentanyl patches for the pain. Nothing interventional will be done unless she worsens. She is followed for medication management over the following years.

Lumbar MRI of November 29, 2007 reportedly showed disc space narrowing at L4-5, L5-S1 with endplate osteophytes and mild subchondral sclerosis. Mild posterior facet arthropathy identified at L4-5 and L5-S1 spine.

Repeat lumbar MRI performed January 15, 2008 was given impression: At the L3-4 level, there is disc desiccation and mild bilateral facet arthropathy. 2. At the L4-5 level, there is disc desiccation, mild disc space narrowing, type 1 modic endplate changes, a diffuse disc bulge, minimal ligamentum flavum hypertrophy, mild bilateral facet arthropathy and a broad-based left foraminal/far lateral disc protrusion producing effacement of the thecal sac, mild right neural foraminal stenosis and moderate left neural foraminal stenosis. 3. At the L5-S1 level, there is disc desiccation, a disc bulge/osteophytes complex and mild bilateral facet arthropathy producing mild left neural foraminal stenosis and moderate right neural foraminal stenosis.

On February 7, 2008 it was noted that she was assaulted by a and fell against a table behind her. She developed low back and bilateral buttock and lower extremity pain which was slowly improving. Orthopedic testing was difficult as the patient was quite guarded at this time. A Caudal epidural injection was considered to be followed by SI joint injections if no relief.

Pain management report dated March 6, 2008 indicated epidural injection was denied. The patient has limited ROM of the lumbar spine worse with extension with positive facet loading bilaterally. She has mild tenderness to palpation over the sacroiliac joints with positive Fabere's bilaterally. Straight leg raise is negative. Strength is 5/5 throughout and sensation is intact. She has axial back pain that appears to be mainly facet related. Epidural injections have been denied. It appears she may benefit from facet steroid injections.

In March 2008 requests for lumbar ESI and facet injections at more than three levels were denied in review.

The patient was deemed MMI per a Designated Doctor evaluation of March 19, 2008 with 5% impairment. The diagnosis given was lumbosacral strain, lumbar degenerative disc disease and lumbar disc (L4-5) protrusion. Per the pain diagram the patient indicated symptoms of pain just inferior to each iliac crest and just superior to the sacrum.

The patient was reevaluated in pain management October 9, 2008 for her left upper quadrant abdominal pain. The examination noted normal inspection/palpation at the sacral spine. Muscle strength was full and symmetric with good tone. Sensation was intact. Reflexes were intact.

The patient was seen in pain management on December 4, 2008 in regard to her low back and leg pain. She has seen a spine surgeon and neurologist who have recommended ESI. Her low back pain is traveling to both lower extremities. Examination notes "no tenderness on the right side of SI joint. No tenderness on the left side of SI joint." A repeat request will be made for epidural injection. The examination also notes normal neurologic function and negative straight leg raise.

The patient underwent a Required Medical Examination on May 12, 2009. The patient's complaints were low back pain and frequent urination. Decreased sensation was noted in the left S1 distribution. Diagnosis was sciatica on the left, consistent with the herniated disc seen on the MRI at left L4-5. Opinion supported a lumbar ESI for the L4-5 disc and a home program using McKenzie disc reduction exercises and spinal stabilization exercises.

The patient was (most recently) reevaluated in pain management on April 12, 2010 for low back pain that radiates to the left lower extremity. No treatment has done well. On examination there is mild midline tenderness in the lumbar paraspinal musculature. Straight leg raising is positive on the left. "No tenderness on the right side of SI joint. No tenderness on the left side of SI joint." Repeat request will be made for a lumbar ESI.

Request for left sided transforaminal ESI at L4-5 and L5-S1 was denied in review on April 19, 2010. On reconsideration May 11, 2010, approval was given for left transforaminal ESI at L4-5.

The patient underwent a Required Medical Examination on May 20, 2010.

On June 14, 2010 approval was given for left L4-5 and L5-S1 transforaminal ESI.

On July 8, 2010 a request for a third lumbar ESI was denied in review with rationale that the patient did not meet the criteria for repeat injection.

Radiographs taken September 1, 2010 showed compression fractures at T11 and T12 and severe degenerative narrowing L4-5 and L5-S1 with no subluxation on flexion/extension views.

Lumbar CT scan performed September 1, 2010 showed stable degenerative changes surrounding L4-5 with mild central canal stenosis and burst fracture of T12. Thoracic spine CT of the same date showed fractures at T11 and T12 with retropulsion of the superior end plates into the central canal.

According to the patient's neurosurgery provider on September 23, 2010 the patient's T11 and T12 vertebra have healed without

any overt cord compression or foraminal stenosis. Her L4-5 interspace is degenerate and could be generating her back pain. Inquiry was made to her hepatologist as to whether her liver disease would prevent any surgical procedure. She complains mostly of left-sided low back pain that occasionally radiates into the left leg. The first two toes on the left are occasionally numb. She has weaned herself out of a back brace for the mid back pain. She has been told that no additional epidural injections will be approved due poor response from the first two injections. She had a lack of response from PT as well. Her cirrhosis doctor has told her never to have an open operation. She has T11 and T12 compression fractures, L4-5 intervertebral disc disease and mild left L5 radiculopathy.

On September 30, 2010 the neurosurgeon requested referral for SI joint injections and pain management.

Request for outpatient left sacroiliac joint injection was considered in review on November 3, 2010 with recommendation for non-certification. Per the reviewer, the patient has a three-year history of back and leg pain with negative/non-diagnostic response to two level transforaminal epidural steroid injections at L4, L5 times two. Note of July 8, 2010 documents absence of right or left SI joint tenderness. Note of October 25, 2010 documents left SI joint moderate tenderness. No provocative SI joint maneuvers are documented. The ODG recommends three provocative maneuvers to establish SI joint mediated pain. A peer discussion was attempted but not realized.

Request for reconsideration outpatient left sacroiliac joint injection was considered in review on November 17, 2010 with recommendation for non-certification. Per the reviewer, the patient has a three-year history of back and left leg pain and has been treated with steroid injections for reported radiculopathy with limited response. Now a sacroiliac joint injection has been requested on the left. It is noted that the exam of 6/10, 7/8, and 7/25/10 documents absence of right or left sacroiliac joint tenderness. Note of 10/25/10 notes left SI joint moderate tenderness. A sacroiliac joint injection was requested and denied as no other sacroiliac joint exam findings were documented. New note of 11/8/10 documents sacroiliac tenderness as well as other reported positive tests. A sacroiliac joint has again been requested. It should be observed that this is a new symptom. Prior notes specifically document the absence of SI joint findings. As such, if current symptoms were related to the date of injury of xx/xx/xx they would have been present before 3 years. Since this is a new symptom, the claimant has not had the specified directed conservative treatment that is required prior to considering sacroiliac injections. A peer discussion was attempted but not realized.

The carrier submitted an IRO review response dated December 8, 2010. First level review denial notes absence of SI joint symptoms and a later note indicating positive provocative maneuvers without clarifying three maneuvers as required by ODG. Second level review denial rationale notes current report of SI joint symptoms would be considered a new symptom and conservative care should be provided prior to request for injection. The treatment history is noted (as above) and the criteria for sacroiliac joint injection cited. As noted by the reviewer, there is no evidence from the provider of attempted conservative treatment since reporting new condition of sacroiliac joint symptoms.

Request was made for an IRO.

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

ODG - Recommended as an option if failed at least 4-6 weeks of aggressive conservative therapy as indicated below. The history and physical should suggest the diagnosis (with documentation of at least 3 positive exam findings as follows: 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).

Sacroiliac joint pain was noted in the first line review to be a new symptom. In fact, SI joint symptoms were noted prior in March 2008: "The patient has limited ROM of the lumbar spine worse with extension with positive facet loading bilaterally. She has mild tenderness to palpation over the sacroiliac joints with positive Fabere's bilaterally. Straight leg raise is negative. Strength is 5/5 throughout and sensation is intact. She has axial back pain that appears to be mainly facet related. Epidural injections have been denied. It appears she may benefit from facet steroid injections." However, later that month the patient herself noted on her pain diagram, symptoms of pain just inferior to each iliac crest and just superior to the sacrum. In October 2008, the examination noted normal inspection/palpation at the sacral spine. The December 2008 examination notes "no tenderness on the right side of SI joint. No tenderness on the left side of SI joint." A repeat request was planned for epidural injection. At the RME in April 2009 no complaints or findings were reported in regard to the sacroiliac joint area. The most recent provider exam is April 2010 and states, "no tenderness on the right side of SI joint. No tenderness on the left side of SI joint." Most recently (September 2010) the patient's neurosurgeon noted she has T11 and T12 compression fractures, L4-5 intervertebral disc disease and mild left L5 radiculopathy.

First line review denial rationale that no provocative SI joint maneuvers are documented (per note of October 25, 2010) has merit. The ODG recommends three provocative maneuvers to establish SI joint mediated pain.

Second line review denial rationale that, since this is a new symptom, the claimant has not had the specified directed conservative treatment (since reporting the new condition) that is required prior to considering sacroiliac injections, also has merit as there has been no indication of sacroiliac joint symptoms since 2008.

ODG states, the history and physical should suggest the diagnosis (with documentation of at least 3 positive exam findings as listed above). This criteria has not been met. In addition, there is no documentation of conservative attempts at treatment

directed to the SIJ. Therefore, my recommendation is to agree with the previous non-certification for outpatient left sacroiliac joint injection.

The IRO's decision is consistent with the following guidelines:

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 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

The Official Disability Guidelines 11-12-2010 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. 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). 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.

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.

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.