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Notice of Independent Review Decision

DATE OF REVIEW: 1/17/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
The item in dispute is the prospective medical necessity of a bilateral SI joint injection (27096).

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation. The reviewer has been practicing for greater than 10 years.

REVIEW OUTCOME

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

☐ Upheld (Agree)

☒ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

The reviewer disagrees with the previous adverse determination regarding the prospective medical necessity of a bilateral SI joint injection (27096).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

According to available medical records, this female worker was injured on xx/xx/xx when she slipped and fell. Following her injury, she complained of right hip and back pain. An MRI of the lumbar spine performed in August, 1991 showed no evidence of disk herniation or stenosis. Records indicate that the injured worker underwent five surgical procedures including a right sacroiliac joint fusion in July, 1992, a left sacroiliac joint fusion in 1993, removal of hardware in 1998, a right sacroiliac fusion in 1999, and hardware removal and refusion of the right sacroiliac joint in February, 2010.

On October 6, 2009, , M.D. performed a Required Medical Evaluation. Dr. reported that the worker was complaining of right sacral pain radiating down the right lower extremity and pain intermittently in the left inguinal area. Tenderness was noted at the right iliac crest, paraspinal area, the sacroiliac joints, and the sciatic notches. Limited flexion, extension, and lateral bending of the lumbar spine were described. Straight leg raising was said to be positive at 75°. Patrick's test was said to be painful. Sensation, strength, and reflexes were intact. Dr. felt that the injured worker was experiencing sacroiliac pain of a chronic mechanical nature with a recent recurrence of symptoms.

On November 13, 2009, M.D. evaluated the injured worker and noted that she had a 16-year history of sacroiliac problems. He recommended a MRI of the lumbar spine and CT guided injection of the sacroiliac joints with Lidocaine and steroids. The right sacroiliac joint was injected on December 22, 2009 and the injured worker obtained relief of her symptoms. A MRI of the lumbar spine performed on December 28, 2009 was said to be "unremarkable."

Dr. recommended surgery on the right sacroiliac joint for removal of hardware and fusion. On February 22, 2010, the worker was taken to surgery by Dr. for removal of the hardware and right sacroiliac joint arthrodesis with iliac crest bone graft. Dr. recommended that the injured worker use a wheelchair for mobility for approximately three months and start weight bearing on or about May 22. The patient began a rehabilitation therapy program on May 25, 2010 and underwent 18 therapy sessions between May 25, 2010 and August 24, 2010.

On June 9, 2010, M.D. evaluated this patient and noted that immediately following her February, 2010 surgery, the patient was experiencing no lower back pain. During March and April, however, her pain began recurring. Dr. prescribed Norco, Tramadol, a Lidoderm patch, Lyrica, and Zipsor.

On June 18, 2010, Dr. reported that the injured worker's pain was 50% better. He planned a CT scan at the end of August to verify the fusion. X-rays of the pelvis done on June 18, 2010 reportedly showed stable right sacroiliac joint internal fixation hardware.

On September 3, 2010, Dr. noted that the injured worker was continuing to have pain on the right side. He recommended CT scanning to evaluate the fusion. He stated that her left side was "getting worse." He noted that she was forming

keloids at her scar site and he recommended more physical therapy for core strengthening.

On November 22, 2010, M.D. reported that the injured worker's pain was more tolerable and better controlled. He noted decreased forward flexion, positive facet challenge, tender lumbosacral and sacroiliac joints bilaterally, right greater than left, a positive FABER's, and positive straight leg raise. He noted that reflexes and sensation were intact. Dr. recommended bilateral sacroiliac joint injections, decreasing Lyrica because she was experiencing side effects from high dose Lyrica, continuation of hydrocodone, and stated that if the injured worker did not get adequate relief from sacroiliac joint injections, she would be referred for consideration of a chronic pain management program.

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

According to available medical records, this injured worker was diagnosed with SI joint dysfunction almost xx years ago. She has received physical therapy, multiple medications, a S-I belt, injections, and 5 surgical procedures all directed towards treating her SI joint dysfunction. Her current treatment providers (orthopedic surgeon, physiatrist, and chiropractor) have all agreed that her current symptoms are due to ongoing SI joint dysfunction, and her history and physical exam findings and imaging studies are consistent with this diagnosis (in spite of the fact that her records mention only one (FABER) of the tests recommended for confirming the diagnosis). The diagnosis is well established and supported by her medical history. Her diagnostic evaluation has addressed other possible pain generators (MRI, musculoskeletal exam and neurologic evaluations have excluded other pain generators). The patient has failed to improve with extensive physical therapy, home exercises, and medication management. Her symptoms are significantly interfering with transportation to and from work and her ability to perform her job. Her current treating physician has indicated that if she fails to respond to the recommended injections, he will recommend a chronic pain management program. Unless she has these injections, she would not have exhausted all possible conservative treatments which would likely result in significant clinical improvement and would not qualify for chronic pain management, should she not respond to the proposed injections. For these above stated reasons, it is my opinion that the intent of the ODG treatment guidelines is met and there is a medical necessity for bilateral sacroiliac joint injections.

ODG Criteria for the general use of multidisciplinary pain management programs:
Outpatient pain rehabilitation programs may be considered medically necessary in the following circumstances:
(1) The patient has a chronic pain syndrome, with evidence of loss of function that persists beyond three months and has evidence of three or more of the following: (a) Excessive dependence on health-care providers, spouse, or family; (b) Secondary physical deconditioning due to disuse and/or fear-avoidance of physical activity due to pain; (c) Withdrawal from social activities or normal contact with others, including work, recreation, or other social contacts; (d)

Failure to restore preinjury function after a period of disability such that the physical capacity is insufficient to pursue work, family, or recreational needs; (e) Development of psychosocial sequelae that limits function or recovery after the initial incident, including anxiety, fear-avoidance, depression, sleep disorders, or nonorganic illness behaviors (with a reasonable probability to respond to treatment intervention); (f) The diagnosis is not primarily a personality disorder or psychological condition without a physical component; (g) There is evidence of continued use of prescription pain medications (particularly those that may result in tolerance, dependence or abuse) without evidence of improvement in pain or function.

(2) Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement.
(3) An adequate and thorough multidisciplinary evaluation has been made. This should include pertinent validated diagnostic testing that addresses the following: (a) A physical exam that rules out conditions that require treatment prior to initiating the program. All diagnostic procedures necessary to rule out treatable pathology, including imaging studies and invasive injections (used for diagnosis), should be completed prior to considering a patient a candidate for a program. The exception is diagnostic procedures that were repeatedly requested and not authorized. Although the primary emphasis is on the work-related injury, underlying non-work related pathology that contributes to pain and decreased function may need to be addressed and treated by a primary care physician prior to or coincident to starting treatment; (b) Evidence of a screening evaluation should be provided when addiction is present or strongly suspected; (c) Psychological testing using a validated instrument to identify pertinent areas that need to be addressed in the program (including but not limited to mood disorder, sleep disorder, relationship dysfunction, distorted beliefs about pain and disability, coping skills and/or locus of control regarding pain and medical care) or diagnoses that would better be addressed using other treatment should be performed; (d) An evaluation of social and vocational issues that require assessment.
(4) If a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits (80 hours) may be implemented to assess whether surgery may be avoided.
(5) If a primary reason for treatment in the program is addressing possible substance use issues, an evaluation with an addiction clinician may be indicated upon entering the program to establish the most appropriate treatment approach (pain program vs. substance dependence program). This must address evaluation of drug abuse or diversion (and prescribing drugs in a non-therapeutic manner). In this particular case, once drug abuse or diversion issues are addressed, a 10-day trial may help to establish a diagnosis, and determine if the patient is not better suited for treatment in a substance dependence program. Addiction consultation can be incorporated into a pain program. If there is indication that substance dependence may be a problem, there should be evidence that the program has the capability to address this type of pathology prior to approval.
(6) Once the evaluation is completed, a treatment plan should be presented with specifics for treatment of identified problems, and outcomes that will be followed.

(7) There should be documentation that the patient has motivation to change, and is willing to change their medication regimen (including decreasing or actually weaning substances known for dependence). There should also be some documentation that the patient is aware that successful treatment may change compensation and/or other secondary gains. In questionable cases, an opportunity for a brief treatment trial may improve assessment of patient motivation and/or willingness to decrease habituating medications.

(8) Negative predictors of success (as outlined above) should be identified, and if present, the pre-program goals should indicate how these will be addressed.
(9) If a program is planned for a patient that has been continuously disabled for greater than 24 months, the outcomes for the necessity of use should be clearly identified, as there is conflicting evidence that chronic pain programs provide return-to-work beyond this period. These other desirable types of outcomes include decreasing post-treatment care including medications, injections and surgery. This cautionary statement should not preclude patients off work for over two years from being admitted to a multidisciplinary pain management program with demonstrated positive outcomes in this population.
(10) Treatment is not suggested for longer than 2 weeks without evidence of compliance and significant demonstrated efficacy as documented by subjective and objective gains. (Note: Patients may get worse before they get better. For example, objective gains may be moving joints that are stiff from lack of use, resulting in increased subjective pain.) However, it is also not suggested that a continuous course of treatment be interrupted at two weeks solely to document these gains, if there are preliminary indications that they are being made on a concurrent basis.
(11) Integrative summary reports that include treatment goals, compliance, progress assessment with objective measures and stage of treatment, must be made available upon request at least on a bi-weekly basis during the course of the treatment program.
(12) Total treatment duration should generally not exceed 20 full-day (160 hours) sessions (or the equivalent in part-day sessions if required by part-time work, transportation, childcare, or comorbidities). Treatment duration in excess of 160 hours requires a clear rationale for the specified extension and reasonable goals to be achieved. Longer durations require individualized care plans explaining why improvements cannot be achieved without an extension as well as evidence of documented improved outcomes from the facility (particularly in terms of the specific outcomes that are to be addressed).
(13) At the conclusion and subsequently, neither re-enrollment in repetition of the same or similar rehabilitation program (e.g. work hardening, work conditioning, out-patient medical rehabilitation) is medically warranted for the same condition
or injury (with possible exception for a medically necessary organized detox program). Prior to entry into a program the evaluation should clearly indicate the necessity for the type of program required, and providers should determine upfront which program their patients would benefit more from. A chronic pain program should not be considered a “stepping stone” after less intensive programs, but prior participation in a work conditioning or work hardening program does not preclude an opportunity for entering a chronic pain program if

otherwise indicated.
(14) Suggestions for treatment post-program should be well documented and provided to the referral physician. The patient may require time-limited, less intensive post-treatment with the program itself. Defined goals for these interventions and planned duration should be specified.

(15) Post-treatment medication management is particularly important. Patients that have been identified as having substance abuse issues generally require some sort of continued addiction follow-up to avoid relapse.

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 FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**