MEDRx

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Notice of Independent Review Decision

DATE OF REVIEW: 11/14/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
The item in dispute is the prospective medical necessity of 27096 S/I Joint Injection and 77003 Fluor Gid & Loclzi NDL/Cath SPI Dx.

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 Orthopedic Surgery.

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 agrees with the previous adverse determination regarding the prospective medical necessity of 27096 S/I Joint Injection and 77003 Fluor Gid & Loclzi NDL/Cath SPI Dx.

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Records were received and reviewed from the following parties:
Texas Department of Insurance
These records consist of the following (duplicate records are only listed from one source):

Records reviewed from Texas Department of Insurance
Texas Department of Insurance

Intake Paperwork

Denials- 11/1/12, 9/27/12

Records reviewed
Texas Department of Insurance
Statement of Pharmacy Services- 9/6/12

Radiology Report- 9/12/12

Office Notes- 9/21/12, 8/30/12

Records reviewed

Test Form- 9/24/12

All records reviewed were duplicates.

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a man. A lumbar MRI dated 9/12/12 revealed an L3-4 degenerative grade one spondylolisthesis of L3-4 with a disc protrusion and possible compromise of the right L3 nerve root. L4–5 revealed a disk-osteophyte complex. L2-3 revealed a disk- osteophyte complex had also been noted similar to that at L1-2. Neuroforaminal narrowing was noted at multiple lumbar levels, as was facet sclerosis. Treating provider records were reviewed in detail. On 9/21/12, the provider documented the ongoing low back and bilateral buttocks pain. The neurologic examination was noted to be intact. There was bilateral SI joint tenderness, finger sign and positive compression. Diagnoses included lumbosacral spondylosis, radiculitis, spondylolisthesis at L3-4 and bilateral sacroiliac joint dysfunction. There is an Attending Physician consideration for diagnostic “as well as therapeutic” sacroiliac joint injections, bilateral. Prior Attending Physician records were also reviewed. Denial letters discussed a lack of specifically-guideline-associated physical findings that would support such injections, along with the lack of extensive non-invasive treatments with outcomes.

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

Recommend denial of requested services. Applicable clinical ODG criteria for sacroiliac (SI) joint mediated pain has not been met. Although some subjective and objective findings have been submitted, these findings incompletely correlate with ODG-associated physical findings for SI joint pathology and/or pain generation in particular. In addition, evidence of a recent and comprehensive noninvasive treatment protocol of medications, therapy and restricted activities has not been submitted prior to such a request.

Reference: ODG Hip/Pelvis Chapter-Sacroiliac Joint Blocks/Injections
Recommended as an option if failed at least 4-6 weeks of aggressive conservative therapy as indicated below.
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)
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 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)