

# INDEPENDENT REVIEWERS OF TEXAS, INC.

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## Notice of Independent Review Decision

**[Date notice sent to all parties]:**

**11/15/2013**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** Appeal Sacroiliac Injection 27096

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

**REVIEW OUTCOME:**

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

Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

## INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Clinical note dated 07/29/09  
Radiology review dated 07/29/09  
Electrodiagnostic studies dated 02/07/11  
Clinical note dated 03/07/11  
Procedural note dated 05/04/11  
Clinical note dated 05/16/11  
Procedural note dated 07/12/11  
Clinical note dated 07/27/11  
Clinical note dated 04/16/12  
Procedural note dated 04/27/12  
Clinical note dated 05/16/12  
CT scan of the lumbar spine dated 06/14/12  
Clinical note dated 08/14/12  
Clinical note dated 08/16/12  
Clinical note dated 02/25/13  
Psychological evaluation dated 03/07/13  
Procedural note dated 03/21/13

Clinical note dated 04/22/13  
MRI of the lumbar spine dated 05/08/13  
Clinical note dated 06/05/13  
Clinical note dated 06/17/13  
Clinical note dated 09/04/13  
Adverse determinations dated 09/13/13 & 10/21/13

#### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who reported an injury regarding his low back on xx/xx/xx resulting in an acute onset of back pain. The clinical note dated 07/29/09 indicates the patient complaining of ongoing low back pain that was rated as 7-8/10. The patient noted an increase in symptoms particularly at night. Upon exam, the patient was able to demonstrate 5/5 strength throughout the lower extremities. The patient was noted to ambulate comfortably and normally. Normal strength was noted at the EHL, the tibialis anterior, the plantar flexors, as well as the quadriceps and hamstrings. Fabre's testing resulted in no significant pain. The note indicates the patient having undergone an MRI which revealed a disc bulge at L4-5 and L5-S1 with a smaller bulge at L2-3. Spondylolisthesis was noted to be reduced in the supine posture. The procedural note dated 07/12/11 indicates the patient undergoing a hardware exploration at L5-S1. The operative note dated 03/21/13 indicates the patient undergoing an epidural steroid injection at the L4-5 level. The MRI of the lumbar spine dated 05/08/13 revealed a previous fusion at L5-S1 with a disc prosthesis and anterior fusion device. Degenerative changes were noted at L2-3 and in the midline at L3-4 and L4-5. No significant neural impingement or foraminal stenosis was noted. Moderate bilateral facet hypertrophy was noted at L5-S1 with mild narrowing of the canal at the L5 level. The clinical note dated 06/05/13 indicates the patient continuing with complaints of low back pain. The patient was recommended for facet injections at that time. The clinical note dated 06/17/13 indicates the patient being recommended for a work hardening program. The patient stated that he was working full duty at that time. The clinical note dated 09/04/13 indicates the patient having undergone a bilateral facet injection on 07/31/13 at the L3-4 level. The patient was unsure as to the benefit regarding the previous injections. The patient was recommended for an SI joint injection bilaterally at that time.

The utilization review dated 09/13/13 resulted in a denial for a sacroiliac joint injection as no significant clinical exam findings confirming the patient's sacroiliac joint involvement were noted upon exam. No evidence was submitted regarding the patient's specific conservative treatments directed towards the sacroiliac complaints.

The utilization review dated 10/21/13 resulted in a denial for a sacroiliac joint injection as no evidence was submitted confirming the patient's completion of conservative treatments addressing SI joint involvement. Additionally, no information was submitted regarding the patient's 3 positive physical examination findings.

#### **ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:**

The documentation submitted for review elaborates the patient complaining of low back pain. An SI joint injection would be indicated provided the patient meets specific criteria to include exam findings confirming the patient's sacroiliac joint involvement and the patient is noted to have completed all conservative treatments. No information was submitted regarding the patient's specific exam findings confirming the SI joint as the pain generator.

Additionally, it is unclear if the patient has completed any conservative treatments addressing the SI joint complaints. Given these findings, an SI joint injection would not be indicated for this patient at this time. As such, it is the opinion of this reviewer that an SI joint injection is not recommended as medically necessary.

## IRO REVIEWER REPORT TEMPLATE -WC

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

#### MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

#### ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

##### 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. (Vallejo, 2006) 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). (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)

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. (Forst, 2006) (Berthelot, 2006) (van der Wurff, 2006) (Laslett, 2005) (Zelle, 2005) (McKenzie-Brown 2005) (Pekkafahli, 2003) (Manchikanti, 2003) (Slipman, 2001) (Nelemans-Cochrane, 2000) See also Intra-articular steroid hip injection; & Sacroiliac joint radiofrequency neurotomy.

Recent research: A systematic review commissioned by the American Pain Society (APS) and conducted at the Oregon Evidence-Based Practice Center states that there is insufficient evidence to evaluate validity or utility of diagnostic sacroiliac joint block, and that there is insufficient evidence to adequately evaluate benefits of sacroiliac joint steroid injection. (Chou, 2009) The latest AHRQ Comparative Effectiveness Report, covering Pain Management Interventions for Hip Fracture, concluded that nerve blockade was effective for relief of acute pain; however, most studies were limited to either assessing acute pain or use of additional analgesia and did not report on how nerve blockades may affect rehabilitation such as ambulation or mobility if the blockade has both sensory and motor effects. (Abou-Setta, 2011)

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.