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Notice of Independent Review Decision

Date: April 15, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Bilateral sacroiliac joint injections with fluoroscopy

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 determinations should be:

X Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Diagnostics (08/23/12 – 08/30/12)
- Office visits (08/30/12 - 02/07/13)
- Utilization reviews (02/20/13, 03/21/13)

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- Utilization reviews (02/20/13, 03/21/13)
- Diagnostics (03/27/13 – 04/02/13)
- Diagnostics (08/23/12 – 01/26/13)
- Office visits (08/30/12 - 02/07/13)
- Procedures (09/26/12, 11/07/12)

ODG criteria have been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who was under a large canopy when an eight-inch pipe that was holding up the ceiling came down. He was standing. The pipe grazed the side of his head and struck his right shoulder, causing him to fall to his knees and twist his back. He then fell to the ground.

2012: On August 23, 2012, the patient was evaluated for injury to multiple body parts. Various diagnostic studies were performed including x-rays and computerized tomography (CT) scans. X-rays of the right clavicle showed a midclavicular fracture with approximately 5 mm of diastases of the fracture fragment. CT scan of the cervical spine was unremarkable. CT scan of the head showed no acute intracranial abnormality. CT scan of the abdomen and pelvis showed mild bibasilar atelectasis, a few nonspecific retroperitoneal and mesenteric nodes, a small umbilical hernia containing only fat, phleboliths in the pelvis, some subtle soft tissue stranding in the subcutaneous fat posterolateral at the level of the right hip possibly presenting some mild contusion, subtle irregular linear lucency in the T9 vertebral body to the left of midline at the superior aspect on evaluation of the osseous elements. One could not strictly exclude a very subtle non-displaced fracture in this location. There was also some irregular linear lucency in the T11 vertebral body superiorly which could represent subtle non-displaced fracture. CT scan of the thorax showed right clavicle fracture and possible upper lobe pulmonary contusion. X-rays of the left knee were unremarkable. CT of the lumbar spine was also unremarkable.

On August 30, 2012, an orthopedic surgeon, evaluated the patient for right shoulder pain that was sharp in nature, left knee pain, and some intermittent axial neck and lumbar pain (without radiating symptoms). He noted that took the patient (ER) on the DOI. Examination showed an abrasion on the right side of the head, subjective tenderness in the left lower ribcage, ecchymosis around the right shoulder, and subjective tenderness at the thoracolumbar junction. The patient's motor exam was limited by his left knee symptoms, which were subjectively very tender with subjectively limited range of motion (ROM). He was walking with a subjectively mildly antalgic gait on the left. reviewed the previous diagnostic findings and diagnosed displaced mid-shaft clavicle fracture on the right, probable meniscal tear of the left knee, possible disc herniation and lumbar strain, cervical strain, vertebral body fracture, and possible rib fracture. He ordered a hyperextension thoracolumbosacral orthotic (TLSO) for the vertebral body fractures and recommended open reduction internal fixation (ORIF) for displaced clavicle fracture.

On August 30, 2012, magnetic resonance imaging (MRI) of the lumbar spine identified: (1) Decreased signal intensity of L5-S1 intervertebral disc and mild reduction in height. (2) At L5-S1, there was diffuse disc herniation by approximately 4 mm reaching up to the thecal sac. The bilateral neural foramina were mildly narrowed. There was no objective evidence of a vertebral body fracture.

MRI of the left knee identified: (1) Focal blistering of cartilage over the medial patellar facet. (2) Focal marrow edema in the posterior aspect of the lateral tibial condyle and in the intercondylar region of tibia likely contusional edema. (3) A partial-thickness radial tear involving the body of lateral meniscus. (4) A tear involving the posterior horn of lateral meniscus reaching up to the inferior articular surface. (5) Mild edema in the subcutaneous planes in the medial aspect of the knee joint. Please correlate with respect to a grade I sprain. (6) A tear involving the femoral attachment of the anterior cruciate ligament (ACL). (7) Mild joint effusion. (8) A Baker's cyst. (9) Edema in the subcutaneous fat in the infrapatellar region.

X-rays of the cervical spine were unremarkable. X-rays of the right shoulder identified a 2-cm displaced fracture in the middle one-third region of the clavicle. X-rays of the lumbar spine identified no fractures.

On August 31, 2012, MRI of the cervical spine identified: (1) Loss of cervical lordosis. (2) Disc desiccation with reduced disc height at C5-C6. (3) Mild spondylotic changes in the cervical spine. (4) Mild reduction in height at the C5-C6 level. (5) At C5-C6, diffuse disc herniation with right posterolateral protrusion measuring approximately 2 mm causing mild narrowing of spinal canal and mild-to-moderate narrowing of right neural forearm.

On August 31, 2012, MRI of the right shoulder showed: (1) Fracture of the clavicular shaft with surrounding soft tissue edema extending in subcutaneous plane. (2) Mild hypertrophic changes at the acromioclavicular (AC) joint causing indentation of supraspinatus fat with mild fluid in the AC joint. (3) Mild tendinitis/focal interstitial tear towards the insertion of supraspinatus tendon.

On September 17, 2012, evaluated the patient for ongoing severe shoulder pain radiating into the neck, left knee pain and neck pain radiating down to the mid thoracic spine. The patient had difficulty sleeping. He was still wearing the sling to his right arm. He had a painful deformity over his right clavicle. The ecchymosis had improved over the past couple of weeks. He still had subjective tenderness over the thoracolumbar junction. His left knee pain limited his motor strength of that extremity. The left knee had slightly diminished flexion. He had lateral joint line subjective tenderness and posterior knee subjective tenderness. He walked with a left antalgic gait. reviewed the diagnostic studies including CT scan findings and MRI findings and diagnosed displaced mid-shaft clavicle fracture on the right, L5-S1 herniated nucleus pulposus (HNP), left knee lateral meniscal tear, and C5-C6 HNP. explained the patient that proceeding with the clavicle ORIF would be more complicated and associated with a higher risk and more complications. It might not have as good a result. The patient wanted to proceed with the procedure at his convenience. recommended cervical and lumbar epidural steroid injections (ESI) and knee arthroscopy. With regards to the possible thoracic fractures, although the patient was having pain, the pain did not appear to be as severe as for the shoulder. The patient had not yet obtained his lumbar orthosis. He recommended same treatment that included simply avoiding heaving lifting.

On October 5, 2012, noted that the patient had undergone an ORIF of his right clavicle on September 26, 2012. The patient reported that since the surgery, his shoulder was significantly better, although he had some incisional pain. obtained x-rays of the right clavicle that showed nice reduction of fracture. On examination, the patient's incision was healing well. He was neurologically intact distally in the right arm. His left knee had lateral joint line subjective tenderness. He had palpable popping posteriorly with ROM going from 0-110 degrees of flexion. He had some lumbar subjective tenderness from L1 to S1 with palpable spasms. He had subjectively decreased lumbar ROM in all directions. The cervical spine also had subjective pain with ROM, mostly due to trapezius tightness. recommended left knee arthroscopy to address the knee popping, and a physical therapy (PT) program for cervical and lumbar spine as well as the right shoulder.

On November 7, 2012, performed left knee arthroscopic lateral meniscal tear debridement.

On November 13, 2012, evaluated the patient for 5/10 left knee pain, 5/10 back pain with burning going into the lower extremities and 2/10 shoulder pain. recommended a lumbar epidural injection and post-injection PT for back and continuing postoperative PT for left knee and right shoulder.

On December 26, 2012, reviewed the first denial letter regarding the recommendation for lumbar ESI. The peer reviewer had stated that the radiculopathy was not clearly demonstrated and there was no mention of record regarding the patient's response to conservative measures such as PT and medications prior to the proposed injections. stated that the patient had exhausted PT and oral antiinflammatory. He stated that the MRI revealed a disc herniation at L5-S1 that was consistent with physical examination findings. He resubmitted the request for lumbar ESI to treat his back pain and lower extremity symptoms.

2013: On January 22, 2013, evaluated the patient for right shoulder/clavicle pain with discomfort on various movements and occasional soreness and stiffness, left knee pain with some discomfort with various movements and occasional soreness and stiffness and mid to low back area pain which was constant and associated with discomfort with side to side movements and soreness and stiffness. The patient continued to experience lower extremity numbness, tingling and weakness (distribution not identified). The patient was uncomfortable sitting in the chair and had difficulty getting out of the chair and on to the examination table. He had severe subjective tenderness in his mid thoracic area more so on the left side as well as the left lumbar region. He had decreased ROM with flexion and extension. Straight leg raises (SLR) elicited some leg pain. His lower extremity motor strength was weakened mostly due to his back. He had some subjective paresthesias along his L5 and S1 distributions bilaterally. recommended MRI of the thoracic spine for mid back pain evaluation and an upper extremity electromyography (EMG). He recommended awaiting the IRO decision regarding lumbar ESI.

On January 26, 2013, MRI of the thoracic spine revealed prior fracture of superior endplate of T11 vertebral body with loss of anterior height by approximately 30% and mildly reduced central height of T9 and T10 vertebral bodies suspicious of prior fractures.

On February 7, 2013, noted that the patient was getting better with his left knee complaints. His main concern was a persistent 6/10 lumbar pain. His back pain radiated to both hips and sometimes up to his mid back. The patient had PT in November, December and January. He had been complaining of left posterior ribcage pain, which was worse with coughing and sneezing and leaning to the left side or lying flat on the back. Examination showed left posterior ribcage subjective tenderness, subjective tenderness in the midline in the lower lumbar region as well as over the bilateral sacroiliac (SI) joints, positive FABERE'S test bilaterally, positive posterior sheer on the right, positive closed book stress test of the SI joint bilaterally, back pain with SLR, positive Kemp's sign on the left more so than on the right. reviewed the MRI findings and previous diagnostic studies and diagnosed status post left knee arthroscopy with meniscectomy, postoperative clavicle fracture, HNP L5-S1 with radiculopathy and T11 wedge fracture. He recommended evaluation by a cardiothoracic surgeon as the patient was having pain coming from his ribcage. In the area where the patient was complaining there could be a problem with the diaphragm or the ribcage. If there was a problem with the diaphragm, he could have a hiatal hernia or something along those lines. withdrew the request for lumbar ESI and converted it to a request for sacroiliac (SI) injections. Those were to be performed under fluoroscopy. He recommended holding PT until the SI injections were performed.

Per the utilization review dated February 20, 2013, the request for bilateral SI injection with fluoroscopy between February 15, 2013, and April 16, 2013, was denied based on the following rationale: *"This is a request for bilateral sacroiliac injection under fluoroscopy. The patient complains of back pain after an injury sustained on August 23, 2012. The patient underwent physical therapy from November 2012 to January 2013. A lumbar MRI (dated August 30, 2012, showed findings of diffuse disc herniation at L5-S1. The physical examination dated February 7, 2013, revealed subjective tenderness over the midline of the lower lumbar region as well as over the bilateral sacroiliac joints. Faber test was positive bilaterally, posterior sheer test was positive on the right, closed book stress testing was positive bilaterally, Kemp sign was positive more on the left than the right, and SLR was also noted to be positive. The physical examination dated January 22, 2013, revealed paresthesia along the L5-S1 distributions bilaterally. However, additional sacroiliac joint examinations such as the Pelvic Compression, Pelvic Distraction, Pelvic Rock, Flamingo and the Fortin Finger Tests were not performed to further support a possible sacroiliac joint pathology. There was no indication that the MRI and physical examination findings of L5-S1 radiculopathy were appropriately and adequately addressed before shifting the attention towards treating the sacroiliac joint region. The medical necessity of this request is not substantiated at this time."*

On March 13, 2013, gave a prescription for nerve conduction study/electromyography (NCV/EMG) of the upper and lower extremities for tingling in the right arm, numbness in the left leg and numbness in the right trapezius region.

Per the reconsideration review dated March 21, 2013, the appeal for reconsideration of bilateral SI injection with fluoroscopy between March 14, 2013, and May 13, 2013, was denied based on the following rationale: *“The patient is a 33-year-old male who reported a work-related injury on August 23, 2012, due to being struck by an object. The current request is for appeal for one bilateral sacroiliac injection with fluoroscopy. Per Official Disability Guidelines, the criteria in order for recommendation of sacroiliac blocks should indicate objective findings on physical exam to suggest at least three positive exam findings. Indication that the patient indicated on examination there was a positive bilateral sacroiliac joint FABER test positive bilaterally. Posterior Sheer test is positive on the right, and a closed-book stress test was positive bilaterally. Kemp's sign was positive, more on the left than the right, and the straight leg raise was also noted to be positive. However, additional examination with positive findings, such as the pelvic compression, pelvic distraction test, pelvic rock test, resisted abduction test, flamingo, and Fortin-finger test were not indicated in this request. The patient reported complaints of back pain after the reported injury on August 23, 2012, and records for review indicate the patient underwent physical therapy between November 2012 to January 2013; however, the documentation submitted for review do not indicate the patient's physical findings after these sessions. Given the above, the request does not indicate necessity to support this request. As such, the appeal for one bilateral sacroiliac injection with fluoroscopy is non-certified.”*

On March 27, 2013, EMG/NCV of the lumbar spine and bilateral lower extremities showed reduction in the motor CMAPs of left peroneal motor nerve as compared to the right as well as EMG findings of mild active denervation at the left lower lumbar (L5/S1) paraspinal muscles and the muscles innervated by the left L5 nerve root. These findings were suggestive of a left L5 subacute lumbar radiculopathy with mild active denervation and reinnervation. There was no evidence suggestive of peripheral neuropathy, myopathy, nerve entrapment or neuromuscular junction disorder of bilateral lower extremities.

On March 27, 2013, EMG/NCV of the cervical spine and bilateral upper extremities showed increased insertional activity, slightly increased spontaneous activity, increased motor unit amplitude and slightly increased polyphasic potentials noted at the right mid cervical (C5/C6) paraspinal muscles and the muscle innervated by the right C6 nerve root. These findings were suggestive of a right C6 mild subacute cervical radiculopathy with mild active denervation and reinnervation. There was prolonged sensory distal latency of the right median nerve. These findings were supportive of mild right median nerve neuropathy and entrapment at the wrist. There was no evidence suggestive of peripheral neuropathy, myopathy or neuromuscular junction disorder of bilateral upper extremities.

On April 2, 2013, CT scan of the chest showed a mild wedge deformity at T10 and T11 with narrowing of the T10-T11 disc space. One could not tell if that was developmental or related to previous trauma. The T10-T11 disc space was slightly narrowed. One could suspect that that was not an acute process but if that was in question, correlation with a nuclear medicine bone scan might be performed.

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

The preauthorization reviewers appropriately denied the requests for bilateral SI joint injections, per ODG criteria. The medical documentation does not support SI joint blocks, per ODG criteria. Lumbar pain often radiates across the area overlying the SI joints, and lumbar pain has not been excluded as a source of radiating symptoms across the SI joint area. There is insufficient objective evidence of SI joint injury that would necessitate SI joint injections. Per ODG, the criteria for recommendation of sacroiliac blocks should indicate at least three positive “objective” findings on physical exam. Some positive findings were documented very late in the treatment course. If the SI joints had been injured, such positive findings should be evident in the documentation from the initial office visit. It was not until over 5 months after initiation of treatment and production of numerous diagnoses that the SI joints were found to have some “positive” findings and the request for bilateral SI joint injections was requested (at the same time, withdrawing the request for lumbar ESIs).

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 [directed specifically toward SI joint dysfunction].

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES