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Notice of Independent Review Decision

**Date: April 29, 2013**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Left SI joint injection

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

Certified by the American Board of Orthopaedic Surgery  
Recertified by the American Board of Orthopaedic Surgery, 2011  
Orthopaedic Sports Medicine Subspecialty CAQ, ABOS, 2011

**REVIEW OUTCOME:**

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

Upheld (Agree)

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

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

**TDI**

- Utilization reviews (01/17/13, 02/25/13)
- Procedure (04/19/12)
- Office visits (09/24/12 – 02/13/13)
- Therapy evaluation (11/20/12)
- Diagnostic (12/18/12)
- Utilization reviews (01/17/13, 02/25/13)

**ODG criteria have been utilized for the denials.**

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

The patient is a male who alleges injuries to his neck and back on xx/xx/xx, ostensibly as the result of a car wreck. The exact mechanism of injury is not described.

On April 19, 2012, evaluated the patient for ongoing cervical pain from a longstanding work-related injury. He had progressive symptoms of pain over months and had undergone extensive conservative treatment. He had an excellent transient response to a C3-C4 injection. Based upon his imaging as well as clinical presentation and a transient response to the injection, it was recommended that he undergo a posterior decompression to decompress the foraminal stenosis at C3-C4 to hopefully avoid fusion surgery. performed posterior cervical laminectomy and foraminotomy at C3-C4 and application of dural graft. Postoperative diagnoses were cervical radiculopathy, disc displacement at C3-C4 and spinal stenosis at C3-C4 on the left.

On September 24, 2012, evaluated the patient for neck and low back symptoms. The patient was overall doing quite well in regards to his neck. His main complaint now was his low back. He complained of subjective severe 50% back pain and 50% leg pain radiating down the left leg, going down the buttock, posterior thigh and to the calf and foot. He was taking medications and was very pleased with the results from his neck. Examination of the lumbar spine showed a large incision with a cavity from prior infection that was healed with secondary intention. He had tenderness at the level of the old incision and at the level above the incision. He had very limited range of motion (ROM). He could forward flex to around 5-10 degrees, extend to 5-10 degrees and rotate and side bend to 5-10 degrees. He had a positive straight leg raise (SLR) on the left and negative on the right. He had +2 patellar and Achilles reflexes bilaterally. Sensory to light touch was slightly decreased around the lateral thigh. He had some mild gastroc soleus weakness at 4/5 compared to 5/5 strength on the right. X-rays dated July 23, 2012, showed prior laminectomy at the L4-L5 with discectomy and fusion and bony fusion across the disc space. assessed post fusion syndrome, status post laminectomy/foraminotomy at C3-C4 on the left and recommended an up-to-date magnetic resonance imaging (MRI) of the low back and electromyography/nerve conduction velocity (EMG/NCV) of the lower extremities. The patient was to follow-up in four weeks after the testing was performed.

On October 22, 2012, noted that EMG was denied and the insurance company had not responded to the MRI request. The patient had not had any further care in regards to his lumbar spine since he was last seen. He continued to report 50% low back pain and 50% radiating leg pain down the left leg radiating into the buttock, posterior thigh and to the calf and foot. He was utilizing medications intermittently for his back and leg symptoms. Examination of the lumbar spine showed a well-healed incision, tenderness in the paraspinous region and 5-10 degrees of forward flexion, extension, rotation and side bending. SLR was positive on the left. He had +2 patellar and Achilles reflexes bilaterally and decreased sensation to light touch along the lateral thigh. He had 4/5 strength in the left gastroc soleus. reviewed the EMG/NCV study from June 2011 that

showed chronic L4 radiculopathy and some questionable chronic left L5 radiculopathy. Diagnoses were post fusion syndrome of the lumbar spine, status post fusion from L4 to S1 and adjacent segment disease of the lumbar spine. recommended MRI and physical therapy (PT) to the lumbar spine.

On November 20, 2012, the patient underwent PT evaluation. He was recommended treatment with dynamic lumbar stabilization exercises.

On December 18, 2012, MRI of the lumbar spine showed the following findings: (1) Mild dextroscoliotic curvature to the lumbar spine. (2) At L5-S1, status post wide decompressive laminectomy and medial facetectomies and anterior interbody fusion. No definite spinal canal or neural foraminal compromise. Conjoined right S2 and S3 nerve roots were noted. (3) At L4-L5, status post right hemilaminectomy and anterior and posterior interbody fusion. No definite spinal canal or neural foraminal compromise. (4) At L3-L4, mild/moderate spondylosis, partial disc collapse posteriorly, shallow diffuse bulging of the annulus, advanced bilateral facet arthropathy, mild attenuation of the thecal sac measuring 9-mm AP, left greater than right subarticular recess stenosis, without definite neural compression with patient supine and minimal left neural foraminal stenosis. (5) Moderate spondylosis, shallow diffusely bulging annuli and facet arthropathy from T10-T11 through L2-L3.

**2013:** On January 2, 2013, noted that the patient had an epidural injection that gave him around 50% relief of his leg pain. The patient was still reporting 50% back pain and 50% leg pain radiating down the buttocks, posterior thigh, to the calf and foot on the left. His pain level was 7/10. He was utilizing medications for his discomfort. noted the patient was having some neck pain. The headaches had resolved completely. Examination of the lumbar spine showed pain over the left sacroiliac (SI) joint area, cavity on the posterior lumbar spine, 10 degrees of forward flexion, extension, rotation and side bending, positive FABER testing on the left, pain with compression of the SI joint on the left and positive SLR on the left. He had +2 patellar and Achilles reflexes bilaterally and decreased sensory to light touch around the lateral thigh. He had 4/5 strength in the left gastroc soleus. reviewed the MRI which showed laminectomies and fusion at L4-L5 and L5-S1 and some partial disc collapse at L3-L4 and lateral recess narrowing, left greater than right. Diagnoses were post fusion syndrome of the lumbar spine, disc desiccation at L3-L4, lateral recess narrowing at L3-L4 and adjacent segment disease and SI joint dysfunction. recommended SI joint injection to try to help relieve the right lower back pain. He opined that the patient would be a candidate for a decompressive laminectomy at L3-L4 on the left if he had excellent relief of his back pain from the SI joint injection.

Per utilization review dated January 17, 2013, the request for SI joint injection was declined, with the following rationale: *"The patient is a male who reported an injury on xx/xx/xx. The documentation submitted for review details that the patient underwent cervical laminectomy and foraminotomy at C3-C4 with the application of a dural graft April 19, 2012. Subsequent clinical notes detail that the patient has complaints of pain to the lumbar spine, with radiating symptoms to the*

*bilateral lower extremities, particularly the left leg, knee, and foot. On physical exam, the patient has very limited range of motion with only 10 degrees of flexion, extension, and rotation, and side bending. On physical exam, the patient has 5/5 strength with the exception of 4/5 strength in the gastroc soleus on the left and decreased sensory to light touch around the lateral thigh. Otherwise, the patient has 2+ patellar reflexes and Achilles reflexes bilaterally. Notes detail that the patient underwent a physical therapy evaluation on November 20, 2012, with subsequent clinical examination detailing pain in the left SI joint area with a positive FABER test on the left and pain with compression of the SI joint on the left. The Official Disability Guidelines detail in the criteria for the use of sacroiliac blocks that the history and physical should suggest the diagnosis, noting that the patient should have at least three positive examination findings. Also, the patient should have undergone and failed at least 4 to 6 weeks of aggressive conservative therapy, to include physical therapy, home exercise, and medication management. However, there was insufficient documentation submitted for review to indicate the patient's functional response to the previous physical therapy attended. Also, the physical therapy evaluation that was completed was to address the patient's lumbar spine complaints. In addition, notes detail that the patient takes his medications intermittently as needed for pain. Moreover, there is insufficient documentation submitted for review to detail that the patient has been tried and failed conservative therapy prior to the request for an SI joint injection. Also, there were insufficient objective clinical findings to detail SI joint dysfunction. As such, the request for SI joint injection CPT code 27096, 77003 is non-certified."*

On February 13, 2013, evaluated the patient for lumbar spine and low back pain. The patient continued to report 6-7/10 pain and 50% back pain and 50% buttock, posterior thigh pain and occasional discomfort in the calf and foot. He was doing well in regards to his cervical spine. noted that the request for SI joint injection was denied. A peer review was not performed. The patient's main complaint continued to be that of low back pain over the SI joint region. Examination of the lumbar spine showed tenderness to palpation over the SI joint, a healed evidence of prior infection and limited ROM. The patient could forward flex to around 10 degrees and extend to 5 degrees. He had a positive Fabere's test on the left for SI joint pain. There was tenderness over the SI joint and pain with compression of the SI joint. He had positive Gaenslen's test and positive thigh compression test on the left. The patient had mildly positive SLR on the left and negative on the right. Deep tendon reflexes (DTRs) were +2 patellar and Achilles bilaterally. Sensory to light touch was decreased around the lateral thigh. There was 5/5 hip flexion, leg extension, leg flexion, tibialis anterior and extensor hallucis longus (EHL) testing bilaterally. There was some gastroc soleus weakness on the left at 4+/5 compared to 5/5 on the right. Diagnoses were post fusion syndrome of the lumbar spine, prior fusion of the lumbar spine, adjacent segment disease at L3-L4 with lateral recess narrowing at L3-L4 and SI joint dysfunction. again recommended a left sided SI joint injection. The patient's majority of back and buttock pain was from the SI joint. He would benefit from diagnostic and therapeutic injection.

Per reconsideration review dated February 25, 2013, the request for left sided SI joint injection was denied, with the following rationale: *“Guidelines indicate: SI joint injections are supported when there are three positive examination findings and when all possible pain generators have been identified. The claimant should have failed at least four to six weeks of aggressive conservative therapy including physical therapy, a home exercise program and use of medication. Records reflect the claimant has ongoing cervical and lumbar spinal pain. There were three positive physical examination findings for the sacroiliac joint pain and symptoms but no documentation the claimant has undergone at least four to six weeks of structured physical therapy for SI joint pain. Physical therapy notes documented lumbar and cervical spinal therapy had been provided and there was no documentation of any sacroiliac joint complaints or treatment. Records do not reflect the claimant has undergone any type of medication management for the sacroiliac joints. The request for SI joint injection is not certified.”*

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

The requests for a left SI joint injection were appropriately denied. The request does not meet ODG criteria on the most basic point: the history alone does not suggest the diagnosis. The claimant has chronic LBP s/p fusion surgery, and this has been the predominant focus of clinical attention prior to the requests for SI blocks. There is insufficient historical and objective imaging evidence that the left SI joint was directly injured by the MOI. LBP often radiates across the region overlying the SI joints, which brings attention to the second point: the pain generator from the low back has not been ruled out. Radiating pain from the low back is the far more medically probable cause of pain near the SI joint region.

**ODG 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:**

**ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**