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Notice of Independent Review Decision

August 17, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Sacroiliac (SI) joint injection bilaterally

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

Orthopedic Physician

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.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who sustained a work-related injury on xx/xx/xx. The patient was x at work when she felt a pop in her back and pain on the right side of the lower back two days later.

From May 27, 2015, through June 1, 2015, there are three sessions of therapy documented. Modalities consisted of therapeutic exercise, neuromuscular re-education, and instructions on home exercise program (HEP). However, the therapy note of June 1, 2015, indicated the patient had completed 12 sessions.

On June 2, 2015, magnetic resonance imaging (MRI) of the lumbar spine was obtained. The study revealed a mild lumbar spine levoscoliosis and to a lesser degree exaggeration of the normal lumbar lordosis; multilevel lumbar spine endplate bony hypertrophy, circumferential disc bulge

and/or facet/ligamentum flavum hypertrophy and L4-L5 L5-S1 annular tears and a questionable right L5 pars defect with associated subluxation and right neural foraminal narrowing with abutment of the exiting right L5 nerve root.

evaluated the patient on June 4, 2015, for low back pain (especially when walking) radiating to the right leg. The pain score was 3. Lumbar spine examination showed full range of motion (ROM) and spasms along the paraspinal muscles. X-rays of the lumbar spine were negative for fracture or dislocation. MRI of the lumbar spine was reviewed. The diagnosis was lumbar sprain. recommended taking over-the-counter medications and referred her for an epidural steroid injection (ESI).

evaluated the patient on June 18, 2015, for low back pain without radiation. Pain level was reported as 4-6-10. The patient was currently working light duty. On examination, straight leg raising (SLR) was negative bilaterally. The sacroiliac (SI) joint was painful bilaterally. Patrick's, Gaenslen's and sacral distraction was positive bilaterally. The diagnoses were sacroiliitis, lumbosacral sprain, lumbar strain, and lumbar herniated nucleus pulposus (HNP). recommended electromyography (EMG) of the right lower extremity and SI joint in bilaterally x1.

Jperformed a peer review on June 24, 2015, and rendered the following opinions: The work event was a physical factor; however, it did not contribute to the temporary exacerbation of a pre-existing medical condition or infirmity. There was no objective evidence provided to show the compensable injury temporarily worsened or exacerbated the pre-existing conditions of multilevel endplate hypertrophy, facet and ligamentum hypertrophy, disc bulges, annular tears and the possible pars defect at L5. The work event was a physical factor; however, it did not contribute to the permanent worsening or a permanent change in the structure or function of the body. The current diagnosis would extend to include a soft tissue strain of the musculature of the lumbar spine. The patient reported that she felt a pop in her back when she stood after mopping. This mechanism of injury would correlate with the compensable injury of a lumbar spine strain. The patient suffered from ordinary disease of life conditions, which were not casually related to the work-related event of April 29, 2015. The MRI findings of the lumbar spine suggested multi-level anterior-sided endplate hypertrophy, mild bilateral facet and ligamentum hypertrophy, a circumferential disc bulge, annular tears and a grade I spondylolisthesis. All of these conditions were pre-existing and degenerative in nature. At this time, there has been no documentation of prescribed drugs being used for a non-work-related injury. The records noted the patient was taking over-the-counter medication six weeks post injury. The compensable injury has resolved. The current complaints and treatment would be related to the pre-existing, ordinary disease of life degenerative processes noted on the MRI of the lumbar spine on June 2, 2015. All of the MU1 findings were pre-existing and degenerative in nature, and were not related to the compensable event of April 29, 2015.

The following additional records were reviewed:

The patient presented on xx/xx/xx, complaining of a popping sensation after standing following

x underneath a desk, with gradual onset of right-sided low back pain with associated radiation to the right leg. The past medical treatment included in an orthopedic evaluation. The review of systems was positive for numbness and tingling in the right lower extremity. The only medication noted that was relevant to the injury was Neurontin. No records from were available from Mexico. The visual analog scale (VAS) was 7/10 at the initial visit. The physical examination of the lumbar spine noted no obvious deformities. The only objective finding was muscle spasms along the right paraspinal area, X-rays of the lumbar spine were obtained and were negative for fracture dislocation. discharged the patient on modified duty, ordered physical therapy, and prescribed Flexeril 10 mg and Lodine 400 mg for the diagnosis of a sprain of the lumbar spine.

On May 13, 2015, the patient was re-evaluated for low back pain with right leg radiculopathy, primarily with ambulation, after attending three physical therapy visits. The physical examination noted a normal gait and a full range of motion with a negative straight leg raise. Decreased muscle spasms along the right paraspinal muscles were appreciated. The patient was advised to take over-the-counter medications, continue physical therapy, and was released to full duty on a trial basis. The patient presented the next day for a re-evaluation due to being unable to perform her duties. The patient was placed on modified duty. Therapy was continued but no dates were documented. re-evaluated the patient on May 20, 2015 noting a decrease in overall symptoms with a pain rating on the VAS of 4/10. The physical examination remained unchanged. The patient was treated with Naprosyn and advised to continue physical therapy. The work restrictions were unchanged.

On May 28, 2015, the patient was seen and treated noting a VAS of 3/10. The physical examination was objective for decreased paraspinal muscle tenderness; otherwise, the examination was unremarkable, An MRI of the lumbar spine without contrast was ordered, noting difficulty with certain body mechanics and the continuation of physical therapy. The patient would continue over-the-counter medication as needed.”

On July 2, 2015, the patient reported complaints of low back pain that was 3/10. Examination findings were unchanged from previous. recommended SI joint injection bilaterally x1.

According to a utilization review dated July 7, 2015, the request for SI joint injection bilaterally was not certified. Rationale: “According to the Official Disability Guidelines, sacroiliac joint blocks are indicated when three positive examination findings consistent with sacroiliac joint dysfunction are noted an physical examination and there is documentation of failure of four to six weeks of aggressive conservative treatment, including physical therapy, home exercise, and medication management. The claimant has attended at least 12 sessions of physical therapy; however, there is no documentation of failure of a home exercise program. The most recent evaluation did not document current oral medication regimen, which had failed to provide significant relief and, as such, the request is not certified. The request for sacroiliac injection bilaterally is not certified.”

On July 9, 2015, noted the patient's complaints were unchanged. pain level was 3/10. The patient felt like a throbbing and was constant. It was better with sitting, elevated lying and reclined position. recommended appealing for the SI joint injections.

On July 17, 2015, the appeal for the SI joint injections was denied with the following rationale: *"The patient had a lumbar strain event on April 2, 2015. Last progress note on July 9, 2015, indicates minimal pain level of 0-3/10 and minimal restrictions due to pain. There is no documented use of trial of non-steroidal anti-inflammatory drug and pain is improving over last four weeks per progress note. Therefore, patient does not meet Official Disability Guideline criteria for sacroiliac (SI) injections since medical management has not been done or failed."*

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

Bilateral sacroiliac joint injections would not be considered medically necessary and appropriate in this case based upon the Official Disability Guidelines. Official Disability Guidelines require a history and physical examination consistent with sacroiliac joint dysfunction to include documentation of at least three positive exam findings that localize to the sacroiliac joint such as Gaenslen's Test, FABER Test, and pelvic compression test. The records fail to document any physical examination findings which localize to the sacroiliac joint. Absent physical examination findings of sacroiliac joint dysfunction, sacroiliac joint injections cannot be certified in this case.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES