



IRO REVIEWER REPORT – WC

DATE OF REVIEW: 05/05/15

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right sacroiliac joint injection, physical therapy 2-3 x 4 weeks - lumbar

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

Board certified in Physical Medicine and Rehabilitation (PM&R)

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute:

- Right sacroiliac joint injection - upheld
- Physical therapy 2-3 x 4 weeks - lumbar - upheld

PATIENT CLINICAL HISTORY [SUMMARY]:

The records available for review indicate that the date of injury is listed as xx/xx/xx. On this date, the claimant developed symptoms of low back pain when the claimant attempted to lift.

A letter of Medical Necessity dated 04/09/14, eight months prior to the 12/28/14 date of injury, requests authorization for an SI joint injection due to positive physical exam findings which include Fortin Finger Test, Patrick's Test, and Pelvic Compression Test.

A lumbar MRI scan obtained on 01/27/15 was documented to reveal findings consistent the presence of small annular disc bulges at the T11-T12 and T12-L1 levels. There was evidence of an atypical hemangioma in the L1 vertebral body.

The claimant was evaluated on 02/18/15. On this date, it was documented that previous treatment in the form of physical therapy services provided with what was described as limited benefit. There was documentation of tenderness to palpation over the lumbar region with a positive FABER maneuver on the right side.

The claimant was evaluated on 03/16/15. On this date, there was documentation of tenderness to palpation over the right sacroiliac joint region.

The records available for review indicate that the claimant received access to treatment in the form of physical therapy on 03/13/15 and 03/16/15.

On 03/31/15, the claimant was evaluated. On this date, there were subjectively symptoms of low back pain with pain over the bilateral sacroiliac joint regions. It was documented that narcotic medication was utilized for management of pain symptoms. Objectively, there was documentation of good strength in the lower extremities with intact sensation and symmetrical reflexes in the lower extremities with a normal gait pattern.

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

At the present time, based upon the medical records available for review, medical necessity for treatment in the form of a right-sided sacroiliac joint injection is not established. Official Disability Guidelines do provide specific criteria with respect to treatment in the form of sacroiliac joint injections. At this present time, the documented physical examination findings are not sufficient to support a medical condition of a sacroiliac joint mediated pain syndrome, based on the criteria set forth in the guidelines. As such, for the described medical situation, Official Disability Guidelines would not support a medical necessity for treatment in the form of a sacroiliac joint injection to the right side.

With respect to treatment in the form of physical therapy services to the lumbar region, the above-noted reference would not support a medical necessity for this form of treatment. The Official Disability Guidelines would not support a medical necessity for treatment in the form of physical therapy services, as it is documented that previous treatment has included access to treatment in the form of physical therapy services. Official Disability Guidelines would support an expectation for an ability to perform a proper nonsupervised rehabilitation regimen for the described medical situation when an individual is this far removed from the date of injury and when past treatment has included access to treatment in the form of physical therapy services. As a result, for the described medical situation, the above-noted reference would not support a medical necessity for treatment in the form of physical therapy services.

Sacroiliac joint injections: Recommended as an option if failed at least 4-6 weeks of aggressive conservative therapy as indicated below.

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:

- MEDICAL JUDGMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ODG - OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**