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IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Sacroiliac joint injection 27096, 76942, 77002

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: American Board Certified Anesthesiologist with experience in Pain management for over 6 years.

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]:

This request is for Sacroiliac joint injection 27096, 76942, 77002 for was injured on the job in.

: H&P: This is male for consultation at the request of for the evaluation of low back, neck, mid back, leg, shoulder, and arm pain. The pain started ago following an MVC and symptoms have been improving. The pain is located in the low back, mid back, neck, left hip, right hip, left shoulder, and right shoulder area and radiates to the bilateral upper extremities and bilateral lower extremities constant pain with a score of 6/10 on the Best day and a score of 8/10 on the worst day. The pain is exacerbated by prolonged sitting, walking, standing, and movement. The pain is mitigated by rest and lying down. Patient denies any fevers, chills, night sweats, bowel incontinence or bladder incontinence. He has been taking Norco 5/325 and duloxetine for pain. He has had MRI's and EMG's pt states he is in the process of having the MRI's repeated, no imaging available today. He has not had injections of surgery. His pain is widespread, but mainly in the low back and shoulders. He has been in chiropractic care/PT, has a Psychiatrist for depression, also a psychologist. Pt has family history of substance abuse but he does not personally have a history of substance abuse. He is taking opioid medication. He is taking hydrocodone. This medication is effective. He last took it yesterday. He has improved functioning while taking the medication. He has not had side effects from the medication. The patient has been active in physical therapy. Past medical history: Depression, Anxiety takes Cymbalta 30mg QD. Light Alcohol user, Never Smoked. Exam Back pain, neck pain, shoulder pain, bilat hip pain, bilat leg pain. Well nourished, well developed, alert, in no acute distress. No deformities noted in the cervical, thoracic spine or ribs.

Progress note: Pre-op phone call: was contacted and confirmation of procedure, instructed to remain NPO after midnight. Past Medical History: ADHD, Anxiety, Chronic pain syndrome, Depression, Lumbago, DDD, Sleep apnea. Pt will arrive for surgery at 7:45am. Instructed to wash with Hibiciens.

Preoperative assessment: Patient Education provided on a pain scale 0-10 and Instructed patient on surgical procedure to relieve anxiety. Transferred to OR: stretcher. Pre-op time out 0842.

Procedure note: Procedure note: Lumbar Intertaminar Epidural Steroid Injection with fluoroscopic guidance. Pre-op Diagnosis: Low back Pain, Lumbar Radiculitis. Post-op diagnosis: same

Progress note: Recovery Activity: Able to move 4 extremities voluntarily, Able to deep breath and cough, pt fully awake, maintains over 92% on room air.

Progress note: Discharge instructions contact for fever, increased bleeding, redness or drainage, uncontrollable bleeding, pain that is not controlled by medication of increasing level of pain.

Progress note: Follow up appointment for low back pain, neck pain, hip pain, arm pain, and shoulder pain. Since the last visit, the patient states the pain has been improving. Current pain intensity is 4/10. The pain is intermittent. The pain is improved with medication and injections. The pain is made worse with physical activity. The patient has not been active in physical therapy or home exercise. He is taking opioid medication. He is taking hydrocodone and it is effective. Opioid risk Low, last opioid was 4 days ago. He states he had very good response to ESI, feels better, has not needed Norco, also has stopped gabapentin. He does however mention left SI joint area pain. Assessment: Chronic pain, Lumbago, Lumbar degenerative disk disease, Sacroiliac joint pain. Will schedule for left SI joint steroid injection. + Yoemans on appropriate affect, intact judgement and insight, Return visit in 1 month

Orders note: Consent for procedure Left SI joint injection. Patient Complains of low back pain.

Progress note: Pre-op phone call: contacted and confirmation of procedure, instructed to remain NPO after midnight. Past Medical History: ADHD, Anxiety, Chronic pain syndrome, Depression, Lumbago, DDD, Sleep apnea. Pt will arrive for surgery at 8:30am. Instructed to wash with Hibiciens.

UR: Non-certify left Sacroiliac joint block with fluoroscopy since there is lack of clinical information. There is question regarding contrast load with fluoroscopy given history of allergy to shellfish with throat closes. There is question regarding objective evidence of the left SI joint as a pain generator given only ONE documented physical finding (yoemans test)- there is question regarding tenderness at the joint and other provocative maneuvers of that joint. Given limited documentation regarding lumbar exam, there is question as to whether other pain generators such as muscular, myofascial trigger points, facets and radiulopathar have been considered or ruled out. Given the chronicity of the case, now there is question as to physical therapy or home exercise programs specifically addressing the SI joint as a possible pain generator. There is question as to requesting providers knowledge of claims history of certification for lumbar surgery as recently as

UR: Determination: A review of the medical provided for this male patient, status post injury provided the following information relevant to the request for Appeal- left sacroiliac joint steroid block injection with fluoroscopy guidance. In an effort to obtain the addition information necessary to support the medical necessity of the request contact of identified previous diagnostic evaluations have addressed any other possible pain generators, that the block would not be performed on the same day as ESI of facet injections, but that he needs to see the patient again to examine for additional positive exam findings, which time he will provide a subsequent guidance is not recommended.

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

There is not enough clinical information to justify the left sacroiliac injection with fluoroscopy. Per ODG, these injections are not recommended for non-inflammatory sacroiliac pathology. In order to justify, there must be documentation of sacroilitis, which is lacking in the medical records provided. Physical exam shows only one documented physical finding (Yoemans test) to point to the left SI joint as a pain generator. Given limited documentation regarding lumbar exam, there is question as to whether other pain generators such as muscular,

myofascial trigger points, facets and radiculopathy have been considered or ruled out. Therefore, this request is non-certified.

Per ODG:

Not recommend therapeutic sacroiliac intra-articular or periarticular injections for non-inflammatory sacroiliac pathology (based on insufficient evidence for support). Recommend on a case-by-case basis injections for inflammatory spondyloarthropathy (sacroiliitis). This is a condition that is generally considered rheumatologic in origin (classified as ankylosing spondylitis, psoriatic arthritis, reactive arthritis, arthritis associated with inflammatory bowel disease, and undifferentiated spondyloarthropathy). Instead of injections for non-inflammatory sacroiliac pathology, conservative treatment is recommended. Current research is minimal in terms of trials of any sort that support the use of therapeutic sacroiliac intra-articular or periarticular injections for non-inflammatory pathology. Below are current reviews on the topic and articles cited. There is some evidence of success of treatment with injections for inflammatory spondyloarthropathy, although most rheumatologists now utilize biologic treatments (anti-TNF and/or disease modifying antirheumatic drugs) for treatment. Also see [Sacroiliac problems, diagnosis](#); [Sacroiliac injections, diagnostic](#).

Current research and reviews available:

[Chou et al., 2009](#): This is a systematic review commissioned by the American Pain Society (APS) and conducted at the Oregon Evidence-Based Practice Center that states that there is insufficient evidence to evaluate validity or utility of therapeutic sacroiliac joint blocks. ([Chou, 2009](#))

[Vanelderen et al., 2010](#): These authors indicate that SI joint intra-articular injections may provide good pain relief for periods of up to 1 year, but give no reference to support this. They indicate periarticular sources of pain should be considered for treatment in addition to intra-articular injections. They describe in detail the Luukkainen et al. randomized trial of 24 patients who received periarticular injections with one month follow up (see below). ([Luukkainen, 2002](#)) They also cite Maugars et al.; a double-blind study evaluating SI joint injections for patients with spondyloarthropathy. The authors recommend intra-articular injections of local corticosteroid. ([Vanelderen, 2010](#)) ([Luukkainen, 2002](#)) ([Maugars, 1996](#))

[Hansen et al., 2012](#): Evidence was considered limited (or poor) for short-term and long-term relief from intra-articular steroid injections or periarticular injections. ([Hansen, 2012](#))

[Manchikanti et al., 2013](#): Evidence was considered limited for SI joint and periarticular injections. ([Manchikanti, 2013](#))

[Cohen et al., 2013](#): Cohen, et al. indicated that evidence for intra-articular injections was weak. They indicated there was moderate evidence supporting intra-articular injections for spondyloarthropathy and anecdotal evidence for beneficial effect in non-spondyloarthropathy pain. The authors listed a prospective study by Fischer et al., that found a mean duration of benefit of 12 months for juvenile patients with spondyloarthropathy who failed to respond to NSAIDs (a German language study). They also listed a study by Hanley et al., that examined 13 patients with inflammatory spondyloarthropathy and MRI evidence of sacroiliitis (the authors of this study indicated the injections were ineffective) .The Maugars study was also cited. ([Cohen, 2013](#)) ([Fischer, 2003](#)) ([Hanley, 2000](#)) ([Maugars, 1996](#))

[Itz et al., 2015](#): This is the Dutch Multidisciplinary Guideline for Invasive Treatment for Pain Syndromes of the Lumbosacral Spine. This group recommended intra-articular SI joint injections as “*only study related*” (because no literature is available, or case reports are insufficient to indicate effectiveness or safety to give a clear recommendation for practice). The two studies cited for support are those by Luukkainen, et al. and Maugars, et al. ([Itz, 2015](#)) ([Luukkainen, 2002](#)) ([Maugars, 1996](#))

[Chou et al., 2015](#): This is a report from the Agency for Healthcare Research and Quality. The evidence was considered insufficient to evaluate sacroiliac joint corticosteroid injections. The one study cited was Luukkainen et al. ([Chou, 2015](#)) ([Luukkainen, 2002](#))

[Kennedy et al., 2015](#): A review was undertaken as a contribution to a multi-society Appropriate Use Criteria Task Force project convened by the International Spine Intervention Society to assess effectiveness of intra-articular steroid injections in treating SI joint pain. Two randomized controlled trials were cited to support moderate strength recommendation for this treatment. The first was Maugars et al., 1996, and the second (Kim et al., 2010) was a study comparing intra-articular prolotherapy versus steroid injection. The authors of the Kim et al., study found that prolotherapy was a more successful therapy. Several observational studies were also cited. ([Maugars, 1996](#)) ([Kim, 2010](#))

Other case series of intra-articular blocks for non-inflammatory pathology:

[Lillang et al., 2009](#): This is a prospective case series of 39 patients who underwent dual diagnostic intra-articular blocks. Twenty-six (66.7%) experienced pain relief of greater than 50% for 5 weeks. Thirteen patients (33.3%) responded for a

shorter term period (mean 4.4 ± 1.8 weeks). Risk factors for shorter term response included history of lumbosacral spinal fusion. ([Lillang, 2009](#))

Research on periarticular or combined periarticular/intra-articular injections:

Luukkainen et al., 2002: This study, which is double-blind and controlled, is commonly cited to support periarticular injections. Twenty-four patients were treated with periarticular injections (13 with steroid and local and 11 with saline and local). Follow up was at 1 month with improvement in the steroid group. ([Luukkainen, 2002](#))

Borowsky et al., 2008: This was a retrospective review of 2 large case series. Patients receiving intra-articular injections alone had a positive response (defined as a 50% drop in VAS pain score or a report that activities of daily living had “greatly improved”) at 3 months of 12.5% versus 31.25% for the combined injections. The authors suggested that significant extra-articular sources of sacroiliac region pain existed and that intra-articular diagnostic blocks underestimated the prevalence of sacroiliac region pain. ([Borowsky, 2008](#))

Research on intra-articular injections for inflammatory spondyloarthropathy (in adults):

Hanly et al., 2000: This is a study of 19 patients with symptoms of inflammatory low back pain. Thirteen had radiographic evidence of sacroiliitis. All patients received bilateral SI joint injections with steroid. Transient improvement was most pronounced at 1-3 months after injection. This did not reach statistical significance by 6 months. The author’s conclusion was that the injections were ineffective in the management of patients with inflammatory spondyloarthropathy. ([Hanly, 2000](#))

Maugers, 1996: This is a double blind study of 10 patients (13 injections) with painful sacroiliitis. In 5/6 joints injected in the treatment group the patients had relief of > 70% compared to 0/7 in the placebo group at one month. Re-injection with corticosteroid occurred at one month with inclusion of 6/7 of the placebo group. Results of this combined group showed 58% success at 6 months. ([Maugers, 1996](#))

Bollow et al., 1996: Sixty-six patients with inflammatory back pain were treated with CT-guided corticosteroid injections. Statistically significant abatement of subjective complaints occurred in 92.5%. at 1.7 ± 1.1 weeks with improvement lasting for 10 ± 5 months

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

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)