

DATE OF REVIEW: 6/11/07**IRO CASE #:****DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Left sacroiliac joint steroid injection.

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

This case was reviewed by a board certified orthopedic surgeon on the MAXIMUS external review panel who is familiar with the condition and treatment options at issue in this appeal.

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)

<i>Primary Dx Code</i>	<i>HCPCS /NDC</i>	<i>Mod</i>	<i>Units</i>	<i>Type Review</i>	<i>DOS</i>	<i>Amt Billed</i>	<i>Date of Injury</i>	<i>Claim #</i>	<i>Uphold / Overturned</i>
724.6				Prospective	5/2/07-7/2/07		x/xx/xx		Uphold
724.6				Prospective	4/17/07-6/17/07		x/xx/xx		Uphold

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for Independent Review by an Independent Review Organization forms – 5/24/07
2. Determination Notices – 4/20/07, 5/7/07
3. Records and Correspondence from Consultants – 4/5/07, 4/16/07, 5/22/07
4. Records and Correspondence from, PA – 4/23/07

PATIENT CLINICAL HISTORY:

This case concerns an adult male who sustained a work related injury on xx/xx/xx. Records provide no details regarding the circumstances of the injury. Diagnoses have included low back strain/sprain, possible disc derangement, and left sacroiliac joint dysfunction. Evaluation and treatment for this injury has included pain medications.

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

The literature does not support the use of steroid injections for treatment of sacroiliac back pain. The effectiveness of this treatment remains unknown. There is no class I data to demonstrate the long term efficacy of sacroiliac joint steroid injections for the back pain. The article by Van Tulder is a metaanalysis of the literature regarding

outcomes of invasive treatment for low back pain which does not support the use of this therapy for treatment of this patient's condition.

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)

Van Tulder, et al. Outcomes of Invasive Treatments for Low Back Pain. Eur Spine J. 2006.