



**DATE OF REVIEW:** 6/27/07

**IRO CASE #:**

**NAME:**

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

Determine the medical appropriateness of the previously denied request for bilateral SI injection x 2.

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

Texas Licensed

**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)

The previously denied request for bilateral SI injection x 2.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Request Letter dated 6/19/07.
- Request for a Review by an Independent Review Organization dated 6/8/07.
- Determination Notification Letter dated 5/22/07.
- Utilization Review Request dated 5/7/07.
- Name of Party Requesting IRO dated (unspecified).
- Additional Physicians or Health Care Providers dated (unspecified).
- Form for Requesting a Review by an Independent Review Organization (IRO) dated (unspecified).
- Utilization Review Agent dated (unspecified).

- Workers' Compensation (WC) Health Care Network Information dated (unspecified).
- Denial Information dated (unspecified).
- Providers Information dated (unspecified).

**PATIENT CLINICAL HISTORY [SUMMARY]:**

**Age:**

**Gender:** Female

**Date of Injury:** xx/xx/xx

**Mechanism of injury:**

**Diagnoses:** Bilateral sacroiliitis.

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

The limited information submitted for review indicated that this is a female involved in a work-related injury on xx/xx/xx secondary to a slip and fall. The original diagnosis reportedly appears to be bilateral sacroiliitis. Of note, there was no radiographic imaging studies reported or submitted for this review. Reportedly, the claimant's lumbar MRI revealed no disc protrusion, a bone scan performed was negative, and an electromyogram (EMG) of 4/11/07 was negative as well. In addition, reportedly, this claimant had a previous back surgery (levels/procedures not specified). Current medication management consisted of tramadol, Soma, and hydrocodone (usages and dosages not specified). Of note, there were no objective findings pertaining to provocative testing of the sacroiliac joint documented in the submitted note for this review. Absent were positive Palpation findings, applicable/palliation maneuvers, pain threshold test suggestive of sacroiliac joint pain include positive Fortin finger test, seated flexion-standing test, or Gillet's test for authorized sacroiliac motion, pain complication with Patrick maneuver, Gaenslen's test, positive distraction and compression tests, tenderness over the ipsilateral sacroiliac joint, and sacrotuberous ligament. Without this, the clinical indication and necessity of the procedure cannot be established.

**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 AND 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).
  - Interventional Pain Management, 2nd Edition, Edited by Dr. Steven D. Waldman, Chapter 50, entitled Sacroiliac Joint.
  - Practice Guidelines, 1st Edition (2004), Spinal Diagnostic and Treatment Procedures (ISIS), edited by M. Bogduk, M.D.

**CompPartners, Inc. hereby certifies that the reviewing physician or provider has certified that no known conflicts of interest exist between that provider and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for the decision before the referral to CompPartners, Inc.**

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