

IRO America Inc.

An Independent Review Organization

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DATE OF REVIEW: 5/8/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

*LEFT SACROILIAC JOINT INJECTION AND
TRIGGER POINT INJECTIONS X 3 lumbar*

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

Board Certified, American Board of Physical Medicine and Rehabilitation

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)

LEFT SACROILIAC JOINT INJECTION is medically necessary.

TRIGGER POINT INJECTIONS X 3 lumbar is NOT medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Case Assignment from TDI, denial letters from URA, Letter from Ace (April 07), IMO (March and April 07), Dr. (November 06, January-April 07), including: Treating physician's notes, peer reviews, case manager notes, physical therapy notes, MMI and impairment rating, EMG-NCV study, (October 06), (October 06), (January-March 07)

PATIENT CLINICAL HISTORY [SUMMARY]:

Ms sustained a low back injury on xx/xx/xx when lifting a manhole cover. PT and medication management have been used but thus far have been inadequately effective in addressing her symptoms. EMG and MRI were negative.

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

The pain location and referral is consistent with sacroiliac joint involvement. The diagnosis of the sacroiliac joint as a primary pain generator is clinical and not dependent on the presence of any imaging or electrodiagnostic findings. The claimant has failed PT and medication therapies and is thus appropriate for a SIJ diagnostic block, and if positive on two separate occasions with two different duration local anesthetics, should reasonably be followed by medial branch nerve ablations of the associated levels. However, after a careful review of all medical records, the Reviewer's assessment is that there is inadequate documentation to support the need for trigger point injections.

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)