



Notice of Independent Review Decision

DATE OF REVIEW: 5/8/07

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Determine the medical appropriateness of the previously denied request for right sacroiliac joint injection and right L3 through S1 facet medial nerve blocks.

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

Texas Licensed M.D. in Pain Management/Anesthesiology and is currently listed on the TDI/DWC ADL List.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- | | |
|---|----------------------------------|
| <input checked="" type="checkbox"/> Upheld | (Agree) |
| <input type="checkbox"/> Overturned | (Disagree) |
| <input type="checkbox"/> Partially Overturned | (Agree in part/Disagree in part) |

Previously denied request for right sacroiliac joint injection and right L3 through S1 facet medial nerve blocks.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Fax Cover Sheets/Comments dated 4/30/07, 4/26/07, 4/19/07, 2/28/07, 4 pages.
- Inc. of Case Assignment dated 4/26/07, 1 page.

- **Request for a Review by an Independent Review Organization dated 4/18/07, 9 pages.**
- **Additional Physicians or Health Care Providers Form (unspecified date), 2 pages.**
- **Determination Notification Letters dated 3/19/07, 3/5/07, 4 pages.**
- **Position Statement Letter dated 4/30/07, 6 pages.**
- **Required Medical Examination dated 11/8/06, 6 pages.**
- **Follow-Up/ Notes dated 3/22/07, 3/8/07, 2/28/07, 2/1/07, 10/16/06, 9/28/06, 16 pages.**
- **Lumbar Spine MRI dated 8/17/06, 1 page.**
- **Pre-Authorization Request (unspecified date), 1 page.**
- **Texas Workers' Compensation Work Status Report dated 3/22/07, 3/8/07, 2, pages.**
- **Electromyogram and Nerve Conduction Studies Results Letter dated 2/27/07, 1 page.**
- **Examination Report/Letter dated 2/26/07, 2 pages.**

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

Patient's age:

Gender: Female

Date of Injury:

Mechanism of Injury: Lifting type.

Diagnoses: Lumbar sprain; status post right S1 level transforaminal epidural steroid injection.

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

after the injury, the patient underwent a lumbar MRI, which was performed on 8/17/06, which revealed a small focal central disc protrusion at the L5-S1 level, which could impinge on either S1 nerve roots, a bony spinal canal, and neural foramina are maintained. No sacroiliac abnormalities were identified. No PARS defects were noted and degenerative disc changes were present. Electromyography (EMG) / nerve conduction velocity (NCV) studies of the lower extremities were performed on 8/18/06 and were negative for radiculopathy. The claimant completed an initial period of conservative therapy of physical therapy and medications. A right S1 transforaminal epidural steroid injection plus neuroplasty procedure was performed on 9/28/06, which resulted in leg pain improvement initially for one week. A required medical examination performed on 11/8/06 by M.D. suggested that the patient has a right L5-S1 radiculitis cord compression. Dr. has knowledge of the information from the claimant's lumbar MRI and EMG/NCV studies. Additionally, he recommended physical therapy treatments and lumbar facet steroid injections. Of note, no documentation was submitted between

11/8/06 and February 2007. Following this, documentation was submitted from the patient's treating physician Dr. and M.D. on dates 2/1/07, 3/3/07, and 3/22/07 revealed the following objective findings of the lumbar spine: L3 through L5 tenderness with paravertebral muscle spasm, straight leg raising test was positive on the right at 25 degrees and on the left at 75 degrees with tingling and numbness in the right leg and no strain noted of the lumbar spine limited to 20 degrees forward flexion, 0 degree extension, a 5.5 degree left side bend and 0 degree right bend, patella tendon reflexes on the right was 1+, and right Achilles tendon reflex was diminished to 1+. There was noted diminished muscle strength of the right foot, plantar and extensor with additionally diminished muscle strength of right knee flexors and extensors and right hip abductors and adductors. The diagnoses included lumbar strain with L5 disc protrusion. A follow-up note submitted on 2/20/07 from the requesting provider, M.D., revealed the patient apparently with low back pain mainly on the right lumbar spine with radiation into the right posterior thigh. The patient characterized her pain as marked in intensity, aching and stabbing rated 8/10. Associated symptoms included numbness in the right posterior thigh, weakness of the right upper leg, and pain with strain disc. There was limited objective findings documented from the treating physician's physical examination. Of note, from it was found a non-surgical finding as per recommendation by, M.D. dated 10/26/07. In the opinion of this reviewer, after evaluating the documentation submitted, the request for the right sacroiliac joint injection and right L3 through S1 facet medial branch blocks are not certified because of lack of relevant clinical information in support of the applications. There were no examination findings of facet or SI joint pain. This patient does not appear, based on the information available to reviewer, to have a reasonable suspicion for sacroiliac joint and/or lumbar facet joint pain. The prior clinical imaging study report of the lumbar MRI did not reveal any face hypertrophy or other facet problems and/or sacroiliac joint arthropathy. There was mention made of myofascial pain in the lumbar paravertebral muscles. This patient appears to have myofascial pain and is probably the reason why the patient's low back is hurting him, however, the IME which was performed did not indicate any sacroiliac joint and/or lumbar facet joint pain problems.

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 CHRIOPRACTIC 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).

Practice Guidelines, 2nd Edition, (2004), Spinal Diagnostic And Treatment Procedures (ISIS), edited by N. 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.