

Notice of Independent Review Decision

DATE OF REVIEW: 03-05-08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Bilateral sacroiliac (SI) joint injection under fluoroscopy

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

Certification by the American Board of Anesthesiology

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)

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Upheld/ Overturned
		Prospective	720.2	27096	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Denial Notices dated 1/14/2008 and 1/28/2008
 Physician Letters/Examinations 1/14/2008, 4/10/2007, 2/3/2006, 12/5/2005
 Procedure notes dated 5/25/2007, 9/13/2006, 2/3/2006
 Independent Medical Evaluation dated 11/15/2006
 X-ray report dated 11/15/2006

Orders dated 1/7/2008

Official Disability Guidelines (ODG) Hip-Sacroiliac joint blocks

PATIENT CLINICAL HISTORY:

This xx-year-old claimant was injured in a motor vehicle accident on xx/xx/xx. The claimant is status post three (3) laminectomy procedures and has had three (3) prior joint injections. The claimant continues with chronic low back and buttock pain.

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

Per the ODG guidelines, prior to the performance of the requested procedure (bilateral SI joint injections with fluoroscopy), the history and physical should suggest the diagnosis of SI joint dysfunction with at least 3 positive exam findings. The supporting documentation only identifies one physical exam finding that is specific for SI joint dysfunction (positive bilateral Patrick's test) with the addition of "positive SI joint tenderness" which is not diagnostic for SI joint dysfunction and may be produced with gluteal or piriformis myofascial pain. The physician does not mention tenderness over the bilateral posterior superior iliac spines (PSIS) which would be more consistent with SI joint dysfunction (Fortin Finger Test). Also, per ODG guidelines the requesting physician has not documented an adequate trial of aggressive conservative treatment for four to six weeks to include physical therapy, home exercise, and medication management.

The claimant has had bilateral SI joint injections with fluoroscopy performed three previous times. These were performed on 2/3/2006, 9/13/2006, and 5/25/2007. Per the procedure notes, follow-up of the 2/3/2006 on 5/2/2006 documents 75% relief but does not document the duration of relief; follow-up of the 9/13/2006 procedure on 9/21/2006 reported "quite a bit of relief," but this was only one week following the procedure and there isn't any further documentation of the duration of benefit; and the final procedure performed on 5/25/2007 was followed-up on 6/11/2007 with a reported benefit of 30% with no further follow-up on the duration of relief. Per the ODG guidelines, a positive diagnostic response is recorded as 80% improvement for the duration of the local anesthetic, and if steroids are injected (which were in all three procedures) the duration of pain relief should be at least 6 weeks with >70% pain relief recorded for these periods. Although the 2/3/2006 procedure reported 75% relief, there was no documented duration of benefit and the physician's progress notes indicate the procedures were "quite effective" and the claimant received "quite a bit of relief" and "significant

improvement," however, there is insufficient information to indicate the percentage improvement and duration of benefit. Therefore, from the documentation presented, the requested procedure is not medically necessary.

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)**