

MEDR X

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Notice of Independent Review Decision

DATE OF REVIEW: 12/10/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The services under review include a left sacroiliac joint injection (27096), Fluoroscopy (77003) and an xray exam of the left SI joint (73542).

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. The reviewer has been practicing for greater than 15 years and performs this type of service in daily practice.

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 reviewer disagrees with the previous adverse determination regarding the prospective medical necessity of a left sacroiliac joint injection (27096), Fluoroscopy (77003) and an xray exam of the left SI joint (73542).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:
Dr. and the group.

These records consist of the following (duplicate records are only listed from one source):
Records reviewed from Dr. : orthopedic report of 10/6/09, orthopedic consult of 8/25/09, MMT and ROM report dated 10/6/09, 7/10/09 lumbar MRI report, 7/10/09 lumbar radiograph report, 7/22/08 left shoulder MRI report, 5/19/08 right shoulder MRI report, 10/9/09 surgery reservation sheet, 11/3/09 denial letter, 10/9/09 precert request form, 10/9/09 Dr. 's procedure order and 11/13/09 denial letter.

Records reviewed from Group: 11/24/09 letter by LHL 009 and IRO request forms, IRO summary report of 11/24/09, form 1 5/19/08, associate statement 5/19/08, 1/21/08 PLN 11, 6/6/08 PLN 9, 7/30/08 PLN 10, 8/21/08 PLN 11, 8/26/09 PLN 11, WMP 76 form 5/19/08, TWCC form 6 5/19/08, various form DWC 73's, 5/19/08 initial paperwork from US Healthworks, 5/21/08, 5/27/08 and 5/28/08 paperwork from Healthworks, 5/29/08, 7/8/08, 8/5/08, 8/22/08, 11/13/08 reports by DC, notes from Rehab on 6/5/08 to 7/4/08, 7/22/08 radiographic report of left shoulder, 8/18/08 report by MD, 9/13/08 EES 14, 10/15/08 report by DC, DWC form 045 dated 2/11/09, 5/24/09 BRC report, 4/27/09 report by MD, 6/24/09 to 9/28/09 reports by MD, 8/11/09 report by MD, 8/25/09 to 10/6/09 reports by MD, MMT and ROM report dated 8/25/09 and progress notes from 10/20/09 to 11/12/09 from Pain and Recovery Clinic.

We did not receive a copy of the ODG Guidelines from Carrier/URA.

PATIENT CLINICAL HISTORY [SUMMARY]:

Over xx year post the date of a twisting, lifting-associated injury, the claimant was noted to have persistent pain located at his sacroiliac joint, despite the passage of time, restricted activities, medications, TENS and therapy. Tenderness and a positive Faber maneuver were noted at that level, along with two other + provocative tests. There was no lumbar tenderness and the neurological examination was normal. An MRI revealed multi-level disc pathology and evidence of distant surgical intervention. The diagnoses included a strain/sprain of the sacroiliac joint. The claimant was considered for a sacroiliac injection to be followed by physical therapy.

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

According to the ODG Guidelines (As applicable to the Sacroiliac region):

Indications for imaging -- Plain X-rays:

- Lumbar spine trauma (a serious bodily injury): pain, tenderness

Fluoroscopy Indications-“Fluoroscopy is considered important in guiding the needle....., as controlled studies have found that medication is misplaced.....in injections that are done without fluoroscopy.”

Criteria for use of therapeutic intra-articular injections are as follows:

No more than one therapeutic intra-articular block is recommended. There should be no evidence of radicular pain, spinal stenosis, or previous fusion. There should be evidence of a formal plan of additional evidence-based activity and exercise in addition to facet joint injection therapy.

The ODG Guidelines warrant further diagnostic X-ray due to the localized painfully tender SI joint that is further 'stressed' by the 3 positive provocative tests including the FABER maneuver. The fluoroscopic-assisted Left SI joint injection is also reasonably required due to the persistent symptoms and exam findings localized to that area. The injury mechanism was lifting and twisting and indeed was of the type, location and apparent severity level to have resulted in the ongoing documented persistent condition of sacroiliac sprain/strain and chronic inflammation. The condition warrants the investigative x-ray and the therapeutic SI injection, fluoroscopically assisted to facilitate optimal placement of the injection, as this anatomical region is difficult to assess via clinical landmarks alone.

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)**

J Man Manip Ther. 2008;16(3):142-52. Evidence-based diagnosis and treatment of the painful sacroiliac joint. Laslett M.