

SENT VIA EMAIL OR FAX ON
Feb/09/2009

True Decisions Inc.

An Independent Review Organization
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DATE OF REVIEW:
Feb/08/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Injection procedure for Sacroiliac Joint, Arthrography and/or Anesthetic/Steroid

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

Board Certified in Physical Medicine and Rehabilitation
Subspecialty Board Certified in Pain Management
Subspecialty Board Certified in Electrodiagnostic Medicine
Residency Training PMR and ORTHOPAEDIC SURGERY

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines
Denial letters 1/6/09, 1/12/09, 1/15/09
PBI 1/5/09, 1/9/09, 1/15/09
Records from Dr 8/26/08 thru 1/8/09
MRI 9/12/08
OP Report 7/3/07

PATIENT CLINICAL HISTORY SUMMARY

This is a xx year old man reportedly injured on xx/xx/xx lifting a flatbed trailer. He had surgery in xxxx reportedly a hemilaminectomy. He failed to improve with it and postoperative epidural injections. He subsequently underwent a revision L4-5 and L5/S1 discketomy and right S1 foramintomy in 2007. He continued to have pain. An MRI done on 9/12/08 showed the prior disc surgery, the L4/5 central herniation, right facet compression of the thecal sac and the L5 nerve root. He had been noncompliant in a pain program. Dr. felt he had pain along the SI regions, and the L3-L5 vertebral regions. He found no neurological loss. There was pain at the SI joints a positive bilateral right sided Patrick and Rock test, and a bilateral Ganeslen

sign. He requested SI injections. Dr. described low back pain, but did not differentiate unilateral or bilateral pain. He described left groin pain and the presence of asymmetrical posterior iliac spines.

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

This is a man with low back pain and failed back syndrome. He did not improve with prior epidural injections.

The ODG is used as a compendium of evidence based medicine in resolving treatment protocols with work related injuries. Most of the SI discussion is in the hip and pelvic treatment chapters. The ODG accepts the role of SI injections, but recognizes the difficulty in establishing the SI joint as the pain generator. It addresses the false positive findings as well. The examination described three positive right sided SI signs, and only one on the left. He failed operative and nonoperative treatment. He has a clinical picture suggestive of SI injury. Further, SI pain is often considered the cause of failed back syndrome. While there may be other sources of pain generator, many have been addressed without resolution of his pain. The difficulty is one of semantics. Dr. requested bilateral injections. The ODG criteria is met only for the right side. The Reviewer could not determine if there was bilateral SI symptoms from the records, but he did have left groin pain that could be explained by SI dysfunction combined with muscle tightness. General protocol would require an all or none approval/denial rather than only injecting the right side. Since there is justification for the right side injection and a reasonable probability of the symptoms are related to the left side as well, then a bilateral procedure can be justified.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICA 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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES

(PROVIDE A DESCRIPTION)