

Notice of Independent Review Decision

DATE OF REVIEW: 07/16/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Sacroiliac joint injection with epidurogram and fluoroscopic guide 72275, 27096, 77003 to complete by 7/24/09

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

The TMF physician reviewer is board certified in anesthesia/pain management with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

It is determined that the sacroiliac joint injection with epidurogram and fluoroscopic guide 72275, 27096, 77003 to complete by 7/24/09 is medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for obtaining a review by an IRO – 07/06/09
- Preauthorization Determination – 06/01/09, 06/26/09

- Office Visit Notes by Dr. – 03/05/09 to 05/21/09
- Operative Report for ESI and Epidurography by Dr – 02/04/09, 04/22/09
- Injection Follow-up Report – 02/19/09
- Report of electrolytes – 01/07/09
- Report of MRI of the lumbar spine – 08/19/08
- Designated Doctor Evaluation – 12/02/08
- Office visit notes by Dr. – 07/24/08 to 12/23/08
- History and Physical by Dr. – 09/24/08
- Initial Pain Consultation by Dr. – 01/06/09

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient sustained a work related injury on xx/xx/xx when he fell from a truck onto his right buttock and developed pain in his lower back. He has been treated with physical therapy, TENS unit, medication and epidural injections. The treating physician is recommending sacroiliac joint injection with epidurogram and fluoroscopic guide 72275, 27096, 77003 to complete by 7/24/09.

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

For sacroiliac joint dysfunction, the ODG suggests that sacroiliac blocks are indicated when four criteria are met. 1) The history and physical should suggest the diagnosis with documentation of at least 3 positive exam findings. Although the documentation regarding special testing results is not clear, the treating physician has clearly documented in the history and physical the patient's sacroiliac joint dysfunction. 2) Diagnostic evaluation must first address any other possible pain generators. The treating physician performed two epidural steroid injections under fluoroscopy without significant pain reduction and thus the criterion is met. 3) The patient has had and failed at least 4-6 weeks of aggressive therapy including PT, home exercise and medication management. These were done and failed. 4) Blocks are performed under fluoroscopy (Hansen,2003). The treating physician has requested that the blocks be performed under fluoroscopy. Therefore, based on the information provided, the sacroiliac joint injection with epidurogram and fluoroscopic guide 72275, 27096, 77003 to complete by 7/24/09 is medically indicated.

**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)