

SENT VIA EMAIL OR FAX ON  
Mar/04/2010

## IRO Express Inc.

An Independent Review Organization

835 E. Lamar Blvd. #394

Arlington, TX 76011

Phone: (817) 349-6420

Fax: (817) 549-0310

Email: resolutions.manager@iroexpress.com

### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Mar/02/2010

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

SI joint injection #3 left with C Arm

**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 1/12/10 and 2/3/10

Dr. 6/19/09 thru 1/26/10

Dr. 11/22/09

MRI 4/7/09

**PATIENT CLINICAL HISTORY SUMMARY**

This is a woman injured on xx/xx/xx. She had no neurological loss. She was found to have left and right lumbar paraspinal tenderness. She had pain on the side with a Patrick test. She had pain with lumbar flexion and extension. She had left SI injections on 6/19/09 and 7/22/09. The follow up appointment on 6/29 showed persistent symptoms, and the second SI injection was less than 5 weeks after the first injection. The note of 11/12/09 noted "that these injections have given her some relief of her leg pain." She continued to have left low back pain. The MRI showed degenerative changes in the L4/5 and L5/S1 region.

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

There are requirements in the ODG for the diagnosis of SI pain. The ODG requires that two of the mentioned tests be present. The records show this person had a positive FABER sign which meets one of the 3 required findings. Two more are required to have a working diagnosis of SI pain. Another requirement is documentation of failed response to

conservative care. The reviewer did not see that provided, but presume it may have been performed. Repeat blocks require at least 70% relief for at least 6 weeks after a steroid was used. She received Kenalog injections. The reviewer did not see that this amount of relief was obtained in the records. In fact the first and second injections were less than 5 weeks apart.

She does not appear to have met the requirements on the physical examination for SI pain. She also did not get the minimally required relief for a repeat SI injection. Therefore, the request is not medically necessary per the ODG requirements.

**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 REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)