

# C-IRO Inc.

An Independent Review Organization  
7301 RANCH RD 620 N, STE 155-199A  
Austin, TX 78726  
Phone: (512) 772-4390  
Fax: (512) 519-7098  
Email: resolutions.manager@ciro-site.com

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Apr/19/2010

**IRO CASE #:**

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

Left S1 Joint Injection (73542 Radiological examination, sacroiliac joint arthrography, radiological supervision and interpretation, 27096 Injection procedure for sacroiliac joint, arthrography and/or anesthetic/steroid, 77003 Fluoroscopic guidance)

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

M.D., Board Certified in Pain Management and Anesthesiology  
American Board of Anesthesiologists.

**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**

ODG Hip Chapter

3/10/10, 3/24/10

TDI Decision and Order 7/20/09

M.D. 3/17/09

Spine and Rehabilitation Centers 12/17/08

M.D. 2/26/10, 5/21/09

Therapy & Diagnostics 2/26/10

Hospitals 10/12/09

Cancer Center 11/6/08

**PATIENT CLINICAL HISTORY SUMMARY**

Per the xx/xx/xx OV note, the patient complains of "low back pain." There is no mention as to whether or not the patient has radicular symptoms. It was noted on the OV note, that the patient has "numbness and tingling going into her leg." On a 3/17/09 note, it was noted that the patient had pain that "radiates down the posterior thigh and proximal calf." She also had a positive straight leg raise on that date of service. The physical exam on 2/26/10 does not

mention any results of a straight leg raise exam, although the neurological exam was normal. The patient was also noted on 2/26/10 to have a positive FABER and positive shear on the left. It is also not clear if the patient has received PT yet for this pain. There is a note on 2/26/10 that states that the SIJ injection would be performed "in conjunction with post injection physical therapy." The patient has a MRI from 10/23/08 that shows a left L5-S1 "paracentral disc herniation abutting and slightly deviating the left L5 nerve root."

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

Per the ODG, "the history and physical should suggest the diagnosis (with documentation of at least 3 positive exam findings as listed: Cranial Shear Test; Extension Test; Flamingo Test; Fortin Finger Test; Gaenslen's Test; Gillet's Test (One Legged-Stork Test); Patrick's Test (FABER); Pelvic Compression Test; Pelvic Distraction Test; Pelvic Rock Test; Resisted Abduction Test (REAB); Sacroiliac Shear Test; Standing Flexion Test; Seated Flexion Test; Thigh Thrust Test (POSH)." Only 2 of these are mentioned in the records. In addition, it is noted that per the ODG, the patient should have failed PT which is not clear from the notes provided for this review. The ODG goes on to state that "diagnostic evaluation must first address any other possible pain generators." The ODG guidelines have not been satisfied in this case. The reviewer finds that medical necessity does not exist for Left S1 Joint Injection (73542 Radiological examination, sacroiliac joint arthrography, radiological supervision and interpretation, 27096 Injection procedure for sacroiliac joint, arthrography and/or anesthetic/steroid, 77003 Fluoroscopic guidance).

**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)