

SENT VIA EMAIL OR FAX ON
Oct/25/2010

Applied Resolutions LLC

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Oct/25/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Bilateral Sacroiliac Joints blocks

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 10/1/10 and 10/11/10
Dr. 8/8/08 thru 9/16/10

PATIENT CLINICAL HISTORY SUMMARY

This is a man with a back injury in xx/xx. He subsequently had a lumbar fusion from L3 to S1 in 10/7. He reportedly had failed back syndrome not responsive to a spinal stimulator. He had relief for several months after several SI injections. There is a request for repeat bilateral SI injections. He reportedly has local tenderness on the exam. There is a reduction in L5/S1 sensation. He was being considered for an ESI for buttock pain.

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

First questions are the presence of the SI region as the pain generator. None of the physical findings required by the ODG were presented. This would suggest that he not be approved. However he had response to prior injections. The IRO reviewer does not have the results of

the prior treatment options advised by the ODG, but again, he has had the injections. It would be confusing to return to the basic workup at this date to determine the appropriateness for the injections. He has had relief for up to 6 months, although never quantified. Although not technically meeting all the requirements, he does meet the alternative ODG cited criteria. ““The publications are guidelines, not inflexible prescriptions and they should not be used as sole evidence for an absolute standard of care. Guidelines can assist clinicians in making decisions for specific conditions...but they cannot take into account the uniqueness of each patient’s clinical circumstances.” The only other alternative may include the use of RF of the SI joints. A recent Meta-Analysis in PM&R 2(9): 842-851 addresses this. The outcomes sound similar for this man. Therefore, the request is medically necessary.

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)