Parker Healthcare Management Organization, Inc.

4030 N. Beltline Rd Irving, TX 75038
972.906.0603 972.255.9712 (fax)

Notice of Independent Review Decision

DATE OF REVIEW: OCTOBER 4, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed right SI joint injection with fluoroscopy and monitored anesthesia and monitored care by a certified RN anesthetist (27096)

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Physical medicine and Rehabilitation, and is engaged in the full time practice of medicine.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

XX Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
720.2	27096		Prosp	1					Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI-HWCN-Request for an IRO- 19 pages

Respondent records- a total of 90 pages of records received from to include but not limited to: letters 8.10.10, 9.8.10; HFCA for DOS 4.20.10; Health Systems note 4.20.10; letters 9.8.10, 8.5.10; DWC form 60; DDE report, Dr., 5.20.10; Spine Care Consultants notes 10.19.09, 6.28.10; M.D. re-eval 7.15.10; Dr. report 6.30.10; Affiliates in physical Therapy note 7.8.10; request for an IRO forms; MRI Lumbar spine 11.12.08; ODG guidelines low back-Thoracic and Lumbar (Acute and Chronic)

Respondent records- a total of 24 pages of records received from URA to include but not limited to: letters 8.10.10; letters 8.5.10; Consultants notes 10.19.09, 6.28.10;, M.D. re-eval 7.15.10; Affiliates in physical Therapy note 7.8.10

Requestor records- a total of 47 pages of records received from Dr. to include but not limited to: TDI letter 9.14.10; PHMO Notice of an IRO assignment; Consultants notes 10.19.09, 6.28.10; letter 7.27.10; Affiliates in physical Therapy notes 1.7.10-7.8.10

PATIENT CLINICAL HISTORY [SUMMARY]:

The medical records presented for review begin with the physical therapy notes dating back to January, 2010. It is noted that there is low back pain, lumbar strain, muscle spasm. Multiple modalities are employed, and dietary changes outlined. A total of eight physical therapy appointments were completed. There is no significant change noted in any other physical assessments reported.

A second course of physical therapy was started in July 2010. However, the notes reflect that the additional 12 sessions of physical therapy were not certified under the utilization review process.

Dr. completed his initial clinical evaluation on October 19, 2009. The reported mechanism of injury was a single episode of slipping at work. The claimant was noted to be XX years old, 4'11" and 140 pounds. The lumbar examination noted straight spinal column, some tenderness to palpation however, "no notable muscle spasm" was appreciated. The assessment was postoperative lumbar spine, status post lumbar fusion, sacroiliac joint arthropathy bilaterally, and mechanical low back pain. It was suggested that a bilateral diagnostic and therapeutic sequelae joint steroid injection be performed.

The next progress note is dated June 28, 2010. It is noted that the claimant continues to complain of low back pain. The pain complaints are to the bilateral lower extremities in the hips throughout the entirety of the lower extremity. The pain complaint notes a visual analog scale of 8/10. These symptoms are reportedly markedly worse since the last evaluation. The current medications include Vicodin, Benadryl, Lipitor and Lunesta.

The physical examination noted an anxious affect; however, the remainder of the physical examination was essentially negative. Seated straight leg rising was reported as positive on the left. The assessment was status post posterior lumbar fusion at L4/5, sacroiliac joint arthropathy bilaterally, lumbar myofascial sprain strain. The true plan was to continue the current medications. Lumbar stabilization in range of motion exercises was outlined.

The prospective request for right sacroiliac joint injection was not certified. It was noted that she was doing reasonably well after the lumbar fusion surgery, however approximately 2 months after the surgery there was a fall event causing an exacerbation of the pain complaints. The initial request was not certified.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S

POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

RATIONALE:
As noted in the Division mandated Official Disability Guidelines "Not recommended in early hip osteoarthritis (OA). Under study for moderately advanced or severe hip OA, but if used, should be in conjunction with fluoroscopic guidance. Intraarticular glucocorticoid injection with or without elimination of weight-bearing does not reduce the need for total hip arthroplasty in patients with rapidly destructive hip osteoarthritis. (Villoutreix, 2005) A survey of expert opinions showed that substantial numbers of surgeons felt that IASHI was not therapeutically helpful, may accelerate arthritis progression or may cause increased infectious complications after subsequent total hip arthroplasty. (Kasper, 2005) Historically, using steroids to treat hip OA did not seem to work very well, at least not as well as in the knee. However, the hip joint is one of the most difficult joints in the body to inject accurately, and entry of the therapeutic agent into the synovial space cannot be ensured without fluoroscopic guidance. Fluoroscopically guided steroid injection may be effective." When noting that this may not be particularly helpful, and that the lesion was to the lumbar spine, there is no clear clinical indication for such an injection of this time.

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
- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- ☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- ☐ MILLIMAN CARE GUIDELINES
- XX 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)