

SENT VIA EMAIL OR FAX ON
Oct/11/2010

P-IRO Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Oct/08/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Bilateral Sacroiliac Joint Injections with Sedation; Post-Injection Physical Therapy Sessions
(97110 X 2)

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 9/8/10, 9/27/10, 9/21/10
Texas Back 7/14/08-9/28/10
OP Report 4/19/10
Pre-OP Internal Medicine Consultation 4/13/10
PT 8/14/10

PATIENT CLINICAL HISTORY SUMMARY

This woman had a back injury in XX/XX. She subsequently had fusion at L4/L5/and S1 in March 2009 that apparently did not improve her pain. The hardware was removed on 4/19/10

and she continues with back pain. Dr. feels she has SI pain based upon positive SI tenderness and FABER signs. He would like to perform SI injections.

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

The ODG questions the value of the SI injection as a diagnostic gold standard. It relies on the clinical findings of at least 3 positive provocative clinical findings. The only one described by Dr. is the positive FABER test. The Fortin test is a possibility, but local SI tenderness is not included. Dr. did not describe the other tests to justify the SI injections.

The criteria of the described in Pain Practice Volume 10, 2010 pages 470-478 also requires that there be 3 of 7 clinical findings that recreated pain. These include 1) Compression test, 2) Distraction test, 3) Patrick sign (FABER), 4) Gaenslen sign, 5) Posterior Shear or thigh trust test, 6) Fortin's finger test and the 7) Gillet test. Pain Practice also recognizes the controversy over the use of SI injections as a diagnostic procedure.

Since both Guidelines agree on the necessity of the 3 positive clinical tests, and Dr. only provided one positive clinical finding, the request is not 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)