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## Notice of Independent Review Decision

**DATE OF REVIEW:** 09/17/10

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of an SI joint injection to the left side (27096, 77003, 72020, J1030, J3490).

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

The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation. This reviewer has been practicing for greater than 15 years.

### **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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of an SI joint injection to the left side (27096, 77003, 72020, J1030, J3490).

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties:  
and Spinal Clinic

These records consist of the following (duplicate records are only listed from one source): Records reviewed from: Denial Letter – 8/5/10 & 9/1/10; TX Evaluation Center PPW Report – 8/20/10; CPMP Progress Notes – 8/18/10-8/20/10; CPMP Weekly Goal Sheet – 8/19/10; MD report – 1/11/10, 5/11/10, & 8/12/10; Spinal Clinic Office Notes – 2/22/10-7/22/10, Electrodiagnostic Study Report – 6/16/10,

Letter of Medical Necessity - 3/24/10, Encounter Summary – 2/22/10; ODG Hip & Pelvis Chapter regarding Sacroiliac Joint Blocks.

Records received from Spinal Clinic were all duplicates of the Carrier's records submitted.

A copy of the ODG was provided by the Carrier/URA for this review.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient was injured while falling at work on xx/xx/xx. He has been managed with analgesic medications, PT, aquatics and NSAID's. The request is for the prospective medical necessity of an SI joint injection to the left side. The patient has requested this review be performed on a life threatening basis.

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

The ODG provide the following criteria for SI blocks:

1. The history and physical should suggest the diagnosis (with documentation of at least 3 positive exam findings as listed above). (This criterion is met)
2. Diagnostic evaluation must first address any other possible pain generators.
3. The patient has had and failed at least 4-6 weeks of aggressive conservative therapy including PT, home exercise and medication management. (This criterion is not met as the reviewer notes that documentation of this is not provided by any party to the review).
4. Blocks are performed under fluoroscopy.
5. A positive diagnostic response is recorded as 80% for the duration of the local anesthetic. If the first block is not positive, a second diagnostic block is not performed.
6. If steroids are injected during the initial injection, the duration of pain relief should be at least 6 weeks with at least > 70% pain relief recorded for this period.
7. In the treatment or therapeutic phase (after the stabilization is completed), the suggested frequency for repeat blocks is 2 months or longer between each injection, provided that at least >70% pain relief is obtained for 6 weeks.
8. The block is not to be performed on the same day as a lumbar epidural steroid injection (ESI), transforaminal ESI, facet joint injection or medial branch block.
9. In the treatment or therapeutic phase, the interventional procedures should be repeated only as necessary judging by the medical necessity criteria, and these should be limited to a maximum of 4 times for local anesthetic and steroid blocks over a period of 1 year.

The reviewer states that the documentation of #3 above has not been met. Therefore, the requested procedure cannot be approved as medically necessary at 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
- 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)