



INDEPENDENT REVIEW INCORPORATED

Notice of Independent Review Decision

DATE OF REVIEW: 11/22/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
left SI joint injection to complete by 12/09/11 (27096)

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., Board Certified in Anesthesiology by the American Board of Anesthesiology with Certificate of Added Qualifications in Pain Management, in private practice of Pain Management full time since 1993

REVIEW OUTCOME:

Upon independent review, I find that the previous adverse determination or determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
724.5	27096		Prosp.	1					Upheld
724.5	27096		Prosp.	1					Upheld

INFORMATION PROVIDED FOR REVIEW:

1. Certification of independence of the reviewer and TDI case assignment.
2. TDI case assignment.
3. Letters of denial 10/07/11 & 10/18/11, including rationale and criteria used in the denial.
4. Treating doctor's (orthopedic) assessments and follow up 10/12/10 – 08/23/11.
5. Operative reports 03/09/11 & 11/02/10.
6. Operative and radiology reports 02/16/09, 03/20/09, 04/20/09 & 08/10/09.

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

**1908 Spring Hollow Path
Round Rock, TX 78681
Phone: 512.218.1114
Fax: 512.287-4024**

This male sustained a back injury on xx/xx/xx. He was treated operatively and has persistent low back pain and leg pain. On physical examination he has tenderness over the left sacroiliac joint.

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

ODG require three positive exam findings to approve SI joint injection. Only one positive finding has been documented. Based on ODG Guidelines, I must deny the request.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR 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 judgment, 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)