

Notice of Independent Review Decision

**IRO REVIEWER REPORT**

DATE OF REVIEW: 12/20/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Injection procedure for sacroiliac joint, arthrography and/or anesthetic/steroid

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

The TMF physician reviewer is a board certified orthopedic surgeon with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

It is determined that the injection procedure for sacroiliac joint, arthrography and/or anesthetic/steroid is not medically necessary to treat this patient's condition.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Information for requesting a review by an IRO – 12/06/10

- Decision letter – 11/19/10, 11/22/10, 11/24/10,
- Letter to TMF from Utilization – 12/07/10
- Response to Pre-authorization from – 11/19/10
- Response to appeal from – 07/15/10, 11/24/10
- Dr. Procedure Orders – no date
- Orthopedic report by Dr. – 06/11/09 to 11/05/10
- Report of Manual Muscle Testing and Range of Motion – 11/15/10
- Report of MRI of the lumbar spine – 05/29/08, 10/12/10
- Report of lumbar myelogram – 10/30/09
- Report of lower extremity electromyography studies – 07/07/08
- Operative Report by Dr.– 04/21/10
- Physician Review Recommendation – 02/08/10
- Request for preauthorization - 06/24/10
- Post-Surgical Physical Therapy Evaluation – 06/18/10
- Review results– 06/08/10
- Consultation by Dr. – 01/15/10, 03/17/10, 09/15/10
- Functional Abilities Evaluation – 03/16/10
- Physical Therapy Daily Progress Notes – 06/16/10
- Operative Report by Dr. – 10/27/09
- Pre-Op Nursing Notes – 10/27/10
- Letter of determination to Dr. – 09/24/09
- Designated Doctor Examination – 08/14/08
- Work capacity evaluation – 02/25/10

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient sustained a work related injury on xx/xx/xx when he was driving a truck and was struck from behind by another vehicle. He was restrained by the seatbelt and he was complaining about pain in his shoulder on the right side, his back, and neck and has been subsequently treated from this time for his neck, back, and shoulder injury. The patient did undergo a surgical procedure on his low back pain with a laminectomy mostly on the right side since his symptoms were mostly right-sided with the bulging of the disc. The patient did have vigorous physical therapy before and afterwards and the patient was treated for his low back area. His neck and shoulder pain (described as 6/10) have remained somewhat constant even with physical therapy. The patient has complained about some intermittent numbness in his lower extremities, but he was having more problems with his right lower extremity than the left with pain and achiness. The patient underwent the lumbar laminectomy on 04/21/10 and six days later he was started on a physical therapy program. He continued to progress and was seen intermittently by the operating surgeon who placed him on the physical therapy that improved his right leg pain. In July of 2010 the patient began to complain of left-sided leg pain and left hip pain. He has some

physical finding including low back pain with a positive gentle test as well as a positive Faber test and point tenderness at the S1 joint. The patient has not had any specific non-operative treatment for his S1 joint or physical therapy for the same. The patient has shown no evidence of improvement and the treating physician has recommended the use of an injection into the left S1 joint under anesthetic.

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

This patient has had an extensive review and has had treatment for his low back pain, but it has not been determined the exact location and reason for the pain in his left leg. The patient has no history of current trauma some after the original injury. He has now developed new complaints which are on the left side versus the right side, which is where most of his symptoms have been previously. He does not meet the ODG guidelines for failure of physical therapy and conservative measures specifically to the S1 joint and there is no documented evidence that the patient has a S1 joint problem versus a low back problem at this time. Since the patient does not meet the ODG guidelines for injection of the S1 joint on the left side and it has not been determined that he has a true S1 joint problem, it is determined that the Injection procedure for sacroiliac joint, arthrography and/or anesthetic/steroid are not medically necessary.

**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)