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An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jul/18/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient bilateral sacroiliac (SI) joint injection as related to lumbar

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

MD, Board Certified Anesthesiologist

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

Official Disability Guidelines
review determinations 06/02/11, 06/13/11
Handwritten note 06/28/11
Follow up notes 04/27/11, 01/26/11, 01/28/09, 02/26/09, 05/05/09, 06/17/09, 07/15/09, 08/26/09, 09/23/09, 03/31/10, 05/26/10, 08/04/10, 10/27/10, 12/15/10
Designated doctor evaluations 02/19/04, 12/22/04, 03/19/07
RME dated 05/17/11
Procedure report 08/26/09
Operative report 08/18/10, 05/22/09
Radiographic report 12/06/02
CMT/ROM testing 09/25/08, 10/30/08, 01/28/09, 02/26/09, 04/30/09, 08/26/09, 11/04/09, 03/31/10, 08/04/10, 12/15/10, 01/26/11
Emergency physician record 12/06/02
Office visit note 09/25/08, 10/30/08, 12/31/08
Electrodiagnostic interpretation 03/16/09

PATIENT CLINICAL HISTORY SUMMARY

The patient is a female whose date of injury is xx/xx/xx. On this date the patient went to sit down and her chair slid out from beneath her, causing her to fall on her buttocks and then onto her back. Treatment to date is noted to include TENS unit, back brace, epidural steroid injections, facet injections, diagnostic testing, dorsal column stimulator implantation on 08/27/04, trigger point injections, 360 degree fusion and removal of spinal cord stimulator in August 2007. The patient is noted to be status post posterior lumbar interbody fusion at L4-5 in January 2001. Designated doctor evaluation dated 12/22/04 indicates that the patient reached MMI as of 11/01/04 with 7% whole person impairment. Electrodiagnostic study dated 03/16/09 revealed evidence of bilateral peroneal motor neuropathy as well as EMG

findings consistent with moderate acute right L5 and S1 radiculopathy. Follow up note dated 04/27/11 indicates that there is point tenderness to palpation to the lumbar paraspinal musculature L2-S1. Particularly sensitive is the left PSIS and left gluteal musculature. Lumbar range of motion is limited with flexion 10, extension 5, right lateral flexion 4, left lateral flexion 12, right rotation 20 and left rotation 10 degrees. There are no motor deficits noted. Motor strength is graded +5/+5. Deep tendon reflexes are +2/+2 with the exception of an absent right Achilles DTR. RME dated 05/17/11 indicates that appropriate treatment includes office visits every 3 months, medication management, lumbosacral support and pain management injections intermittently during exacerbations.

A request for sacroiliac joint injection was non-certified on 06/02/11. The review noted that none of the provocative SI joint testing had been performed and that it was not clear that the pain generator of radiculopathy has been addressed by the caudal block. This denial was upheld on appeal dated 06/13/11 noting that there is no mention of SI signs on physical examination.

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

The Official Disability Guidelines support SI joint injections with documentation of at least 3 positive findings on physical examination. The submitted records fail to document any positive findings for SI joint dysfunction. It is unclear if all other possible pain generators have been evaluated. Given the current clinical data, the reviewer finds that this request for Outpatient bilateral sacroiliac (SI) joint injection as related to lumbar is not indicated as 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 KNOWLEDGBASE

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)