

# I-Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** May/11/2011

**IRO CASE #:**

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

Right S1 joint injection 27096

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

MD, Board Certified Anesthesiologist and Pain Management

**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, Low Back Chapter

Utilization review determinations dated 03/17/11, 04/18/11

Precertification request dated 03/11/11, 04/01/11

Initial consultation notes dated 02/11/11

MRI of the lumbar spine dated 01/21/11

Office visit note dated 01/25/11

Letter of reconsideration dated 03/31/11

**PATIENT CLINICAL HISTORY SUMMARY**

The patient is a female whose date of injury is xx/xx/xx. On this date the patient fell on her right side with most of the force absorbed by the buttock/pelvis area. MRI of the lumbar spine dated 01/21/11 revealed 2.5 mm very broad based posterior protrusion at L1-2 level; 1-2 mm very broad based spondylitic posterior protrusion at L3-4 level; mild bilateral L3-4 and minimal right L4-5 neural foraminal stenosis; and mild multilevel bilateral lumbar facet arthrosis. Consultation dated 02/11/11 indicates that most of the patient's pain is in her right buttock region. The patient has participated in physical therapy and medication management. On physical examination there is tenderness to palpation to the right SI joint. FABERE test is positive on the right. Seated straight leg raising is negative for nerve root tension signs. Reflexes are 2 symmetrical, and motor power is grossly 5/5. Initial request for right SI joint injection was non-certified on 03/17/11 noting that documentation submitted for review contained only one exam finding that was positive and documentation was insufficient to note that the patient had tried and failed at least 4-6 weeks of aggressive therapy prior to consideration for injection. The denial was upheld on appeal on 04/18/11 noting a lack of physical examination findings and lack of documentation regarding conservative treatment.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS**

**AND CONCLUSIONS USED TO SUPPORT THE DECISION**

On physical examination there is tenderness to palpation to the right SI joint. FABERE test is positive on the right. Seated straight leg raising is negative for nerve root tension signs. Reflexes are 2 symmetrical, and motor power is grossly 5/5. The Official Disability Guidelines require 3 positive physical examination findings to establish the diagnosis of sacroiliac joint dysfunction. In this case there is only 1 positive physical exam finding. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review to establish that the patient has had and failed at least 4-6 weeks of aggressive conservative therapy including PT, home exercise and medication management as required by the Official Disability Guidelines. Given the current clinical data, the reviewer finds the requested Right S1 joint injection 27096 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)