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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Apr/23/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Series of Three Left Sacroiliac Joint Injections

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
MD, Board Certified Anesthesiologist
Board Certified Pain Management

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:
[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Official Disability Guidelines
Utilization review determination dated 02/15/11, 03/07/11
Appeal letter dated 03/29/11, 02/27/11
Reconsideration form dated 02/28/11
Medical records Dr.
Orthopedic consultation dated 11/16/10
Medical records Dr.
MRI of the thoracic spine dated 05/08/10
MRI of the cervical spine dated 05/08/10
MRI of the lumbar spine dated 10/26/09, 05/07/10
Radiographic report lumbar spine dated 10/16/09
Referral form dated 12/16/09
PT note dated 12/16/09
Handwritten lumbar spine evaluation dated 02/10/10
Physical therapy reevaluation dated 02/14/11
Evaluation dated 02/22/11
Impairment rating dated 01/11/11
EMG/NCV dated 10/03/09

PATIENT CLINICAL HISTORY SUMMARY
The patient is a female whose date of injury is xx/xx/xx. On this date the patient was injured while breaking up a fight. There is an EMG/NCV submitted for review dated 10/03/09 (prior to the date of injury), which revealed findings that may be supportive of a right L5 nerve root compression. PT note dated 12/15/09 indicates that the patient completed 10 sessions of PT. Initial evaluation dated 12/16/09 indicates that the patient has done well with aquatic therapy. The patient was referred to Dr. “for some injection therapy as this has provided her

relief in the past". MRI of the lumbosacral spine dated 05/07/10 revealed minimal disc bulges at L3-4 and L4-5 with no significant spinal canal stenosis. Progress note dated 10/19/10 indicates that the patient underwent left SI joint injection that relieved her pain 80-90% for several months on 10/29/09, left L5 and S1 TFESI with no relief on 04/29/10, and left SI joint injection on 10/10/10 with 20% relief. Orthopedic spine consultation dated 11/16/10 indicates impression of chronic left sacroiliac joint sprain with evolving chronic pain syndrome, and the patient was recommended for a series of SI joint injections. Impairment rating dated 01/11/11 indicates that the patient has not reached maximum medical improvement. The patient is dependent upon a cane for painful, slow ambulation.

Evaluation dated 02/22/11 indicates that the patient complains of left lower back and gluteal pain. On physical examination straight leg raising is negative on the right and positive on the left. Faber is negative bilaterally. Romberg test is negative. Lumbar range of motion is restricted. Strength is rated as 5/5 throughout. Deep tendon reflexes are intact 2+ throughout. Sensation is intact. The note states that the patient "has bizarre symptoms that are not typical for lumbar conditions."

Initial request for series of three left SI joint injections was non-certified on 02/15/11 noting that the submitted records fail to document at least 3 positive exam findings (records note only positive Patrick's sign). There is no documentation of diagnostic evaluation first addressing any other possible pain generators, and the previous injection did not provide at least 70% pain relief for at least 6 weeks. The denial was upheld on appeal dated 03/07/11 noting the patient's physical examination fails to document three positive exam findings. The patient underwent previous left SI joint injection in October 2010 and noted only 20% relief, duration not noted.

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

Based on the clinical information provided, the reviewer finds that the request for Series of Three Left Sacroiliac Joint Injections is not medically necessary. The patient's physical examination fails to document three positive exam findings to establish the diagnosis of sacroiliac joint dysfunction, as required by the Official Disability Guidelines. The patient underwent previous left sacroiliac joint injection in October 2010 and noted only 20% pain relief; however, duration of relief was not documented. ODG supports repeat SI joint injection with evidence of at least 70% pain relief for at least 6 weeks. The Official Disability Guidelines do not support a series of SI joint blocks as repeat injections are only supported with evidence of adequate response to previous blocks. The reviewer finds that Series of Three Left Sacroiliac Joint Injections 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
[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
[ ] MILLIMAN CARE GUIDELINES
[X] 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)