

SENT VIA EMAIL OR FAX ON  
Aug/31/2011

## Pure Resolutions Inc.

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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**  
Aug/31/2011

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**  
SI Joint Injection Left

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

**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**

OD Guidelines

1. Utilization review determination 07/08/11 recommending non-certification injection SI joint left
2. Utilization review reconsideration decision 07/26/11 regarding non-certification SI joint injection left
3. Physical therapy initial evaluation and plan of care 10/09/08
4. Utilization review authorization recommendation 10/20/08 regarding physical therapy 3 times a week x 4 weeks
5. MRI lumbar spine 11/04/08
6. Utilization review non-authorization recommendation 11/12/08 regarding physical medicine treatment 3 times a week x 3 weeks
7. Preauthorization request for purchase of electrical muscle stimulator 11/25/08
8. Initial medical report and office visit notes D.C. 11/07/08-05/26/11
9. Initial consultation notes and follow-up notes M.D. 12/02/08-07/27/11
10. Initial consultation D.O. 05/19/11
11. Utilization review non-authorization recommendation 12/26/08 regarding left L5-S1

lumbar epidural steroid injection

12. Procedure notes lumbar epidural steroid injection 02/17/09
13. Procedure note Sacroiliac joint block on left dated 03/23/09
14. Procedure note left SI joint injection 06/07/11

#### **PATIENT CLINICAL HISTORY SUMMARY**

The injured employee is a female whose date of injury is xx/xx/xx. She reportedly was injured when a passenger's bag fell out of overhead storage area injuring her low back. MRI of lumbar spine dated revealed L5-S1 very minor degeneration without focal protrusion. There is no focal protrusion or herniation at any level. There is no evidence of central canal or foraminal stenosis. There is no focal impingement upon the thecal sac or nerve roots at any visualized lumbar area. There is mild bilateral facet osteoarthritis at L3-4, L4-5 and L5-S1. The patient is treated conservatively with medications, physical therapy, and epidural steroid injections. The injured employee also underwent left SI joint injection on 06/07/11. The patient was recommended to undergo repeat left SI joint injection.

A utilization review determination dated 07/08/11 recommended non-authorization of SI joint injection left. It was noted the injured employee received an SI joint injection on 06/07 under fluoroscopic guidance reporting she had obtained good but incomplete pain relief from injection. Clinical examination on 06/29/11, Dr. noted the injured employee to have localized tenderness over the left sacroiliac joint. Current nationally accepted practice guidelines support repeat injections after 8 weeks for patients who obtain greater than 70% relief from prior injection with maximum of 4 injections per year. It was noted that since the injured employee's last injection was less than 4 weeks ago, the request does not meet accepted clinical practice guidelines as published in Official Disability Guidelines.

A utilization review determination dated 07/26/11 recommended non-authorization of reconsideration request for SI joint injection left. It was noted that the injured employee experienced pain relief from initial block as well as improvement with activities of daily living. On 06/29/11 the injured employee complained of low back pain and coccygeal pain. She had left sacroiliac joint injection with pain relief. On examination there was tenderness of the left SI joint and left sciatic notch. SI joint injection with arthrography was recommended. ODG guidelines recommend SI joint injections for SI joint pain following failure of conservative treatment such as 4-6 weeks of comprehensive exercise program, local icing, mobilization / manipulation and anti-inflammatories. The injured employee has undergone left sacroiliac joint injection on 03/23/09 and 06/07/11. ODG guidelines indicate repetition of any injection is recommended with relief of symptoms and objective functional improvements. There was noted improvement of function and decreased pain; nevertheless, pain has not been quantified, no reduced pain medications noted, and objective gains not outlined. As such, medical necessity was not established for left SI joint injection.

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

Based on the clinical information provided, medical necessity is not established for SI joint injection left. The injured employee sustained an injury to low back on xx/xx/xx. She was initially treated with medications, physical therapy, and epidural steroid injections. The injured employee underwent left SI joint block on 03/23/09 and reported approximately 50% reduction in symptoms. On 04/28/09 the injured employee stated she is approximately 80% better. The injured employee underwent a second left SI joint injection on 06/07/11. The injured employee was noted to have achieved good pain relief, but the amount of relief was not quantified. There is no indication the injured employee was able to reduce medications. Although the injured employee reportedly had improved in function, there is no objective documentation. Per ODG guidelines, duration of pain relief following SI joint injection should be at least 6 weeks with at least 70% pain relief. Noting there is no objective assessment indicating the injured employee obtained at least 70% pain relief lasting at least 6 weeks following SI injection on 06/07/11 and noting there is no indication of decreased medications or increased functionality, the request for left SI joint injection is not indicated as medically

necessary. The previous reviews correctly recommended non-authorization and should be upheld on IRO.

**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)