INDEPENDENT REVIEW INCORPORATED

Notice of Independent Review Decision

REVIEWER'S REPORT

Date notice sent to all parties: July 23, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Bilateral SI injections.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
M.D., F.A.C.S., board certified orthopedic surgeon with extensive experience in the evaluation of patients suffering spine and pelvic problems after trauma.

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)

Primary Diagnosis Code	*Service Being Denied*	*Billing Modifier*	*Type of Review*	*Units*	*Date(s) of Service*	*Amount Billed*	*Date of Injury*	*DWC Claim #*	*Upheld Overturn*
847.3	*27096*		*Prosp.*						*Upheld*

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

1. Certification of independence of the reviewer and TDI case assignment.
2. TDI case assignment.
3. Letters of denial 06/21/12 & 05/31/12, including screening criteria used in the denial.
4. Medical records review 06/21/12.
5. MRI lumbar spine w/o contrast 04/26/12.
6. Treating doctor's evaluation/follow up 05/22/12 & 06/12/12.

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a female who suffered a fall while at work on xx/xx/xx. The claimant has a past history of lumbar fusion approximately three years prior to this injury. She has had persistent low back pain in spite of medications, including tramadol, tizanidine, hydrocodone, Skelaxin, and Xanax. She has FABER 4 test positive and tenderness over the sacroiliac joints. The MRI scan of 04/26/12 defined lumbosacral spine pathology. There is no description of sacroiliac joint

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pathology. The claimant has persistent symmetrical deep tendon reflexes and the straight leg raising test is negative bilaterally. The request to pre-authorize bilateral sacroiliac joint injections under fluoroscopy was considered and denied; it was re-considered and denied.

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

This claimant has minimal signs of sacroiliac joint dysfunction. She does have FABER 4 test positive currently. There is no description of sacroiliac joint sclerosis on plain x-rays. There is no description of pathology at the sacroiliac joints on the MRI scan of the lumbosacral spines. There is no description of the use of a sacroiliac joint belt or other signs that would suggest sacroiliac joint pathology. The prior denials of this request to pre-authorize sacroiliac joint injections were appropriate and should be upheld.

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
- 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)

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