

SENT VIA EMAIL OR FAX ON
Dec/30/2011

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Dec/29/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

ODG L Sacroiliac Joint Injection 27096-76942 Celestone 6mg Marcaine 25mg

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

Board Certified Anesthesiologist
Board Certified Pain Medicine

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

Request for IRO dated 12/13/11

Request for IRO dated 11/08/11

Utilization review determination dated 10/20/11

Utilization review determination dated 11/01/11

MRI lumbar spine dated 01/02/07

Clinical records Dr. dated 01/04/07, 11/02/07, 02/10/11, 06/03/11, 07/12/11, 09/14/11, and 10/11/11

Lumbar myelogram dated 04/09/07

Procedure report lumbar epidural steroid injection dated 10/16/07

Procedure report lumbar epidural steroid injection dated 11/06/07

MRI lumbar spine dated 09/02/08

CT myelogram lumbar spine dated 11/06/08

Clinic note Dr. dated 11/13/08

Operative report dated 12/10/08
Physical therapy treatment records
MRI lumbar spine dated 02/23/11

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female who is reported to have sustained work related injuries on xx/xx/xx. The claimant initially presented with low back pain and right groin pain. She was referred for MRI which noted degenerative disc disease and marked narrowing at L4-5 levels with disc material noted in right lateral recess and neural foramen. Records indicate the claimant underwent a course of conservative treatment without improvement. She was noted to have undergone CT myelogram on 02/09/07 which notes multilevels of mild facet arthritis, mild disc degeneration at L3-4, moderate disc degeneration at L4-5, evidence of small left laminectomy defect, and diffuse bulging disc but minimal compression at L5-S1. Records indicate the claimant underwent lumbar epidural steroid injections on 10/16/07, 11/06/07. She had no significant relief with these procedures. MRI of lumbar spine dated 09/02/08 showed degenerative disease at L4-5 with small approximate 4 mm left lateral disc herniation and evidence of previous partial left laminectomy at L4-5 level. The claimant was ultimately seen by Dr. who took the claimant to surgery on 12/10/08. She is noted to have marked stenosis with history of increasing neurogenic claudication. She underwent decompressive laminotomies at L3, L4 and L5 with bilateral foraminotomies at L3-4 and L4-5. The claimant was subsequently diagnosed with failed back surgery syndrome and seen by Dr. for pain management. Current medication profile includes Kadian 60 mg bid, Lyrica 150 mg tid, ibuprofen 800 mg bid, and Restoril 30 mg qhs. The claimant underwent repeat MRI on 02/23/11. This study notes no evidence of focal disc herniation or nerve root compression. There are changes of severe spondylosis at L4-5 with osteophyte disc complex causing thecal sac indentation and mild narrowing of neural foramina. There is degenerative disease at all levels. Records indicate the claimant was seen in follow-up monthly receiving prescription refills. On 10/11/11 the claimant had increasing pain in lumbosacral area on left. Medications have not been as helpful with pain. On examination she is reported to have positive Flamingo test, positive Gaenslen's, and positive Faber's over left SI joint. She subsequently is opined to have sacroiliitis and recommended to undergo left SI joint injection.

The initial review was performed by Dr. on 10/20/11. Dr. non-certified the request noting the claimant's compensable injury is limited to the low back, right hip, and right lower extremity. The records do not provide any indication that the claimant has undergone a recent course of conservative treatment for her left SI joint complaints. She has not undergone treatment with a sacroiliac joint belt or had focused physical therapy, and therefore she would not meet criteria per the Official Disability Guidelines for the performance of this procedure.

The subsequent appeal request was reviewed on 11/01/11 by Dr. who non-certified the request noting that the claimant presented with left lumbosacral pain. Physical examination is reported to show positive flamingoes and Gaenslen's and Faber tests of the left SI joint. He notes that the records did not provide documentation of other possible pain generators to be targeted and addressed. He notes that there is no objective documentation of failure of optimized pharmacotherapy. He notes that there is no further documentation of failure of recent ongoing active rehabilitation efforts. He notes that the CPT code implies ultrasonic guidance and current evidenced-based guidelines recommend that the injection be performed under fluoroscopy. He subsequently notes that the previous non-certification is upheld and non-certified the request.

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

The request for left sacroiliac joint injection is not supported as medically necessary. The submitted clinical records indicate that the claimant does not meet criteria per Official Disability Guidelines for this procedure. While the claimant is reported to have positive findings suggestive of sacroiliac injuries the record does not include supporting documentation establishing the failure of conservative treatment. There's no indication of

progressive physical therapy to include the use of a sacroiliac joint belt. Further the record contains no imaging studies suggestive to establish the presence of sacroiliac joint sclerosis based upon the available clinical data. The previous utilization review determinations were appropriate and subsequently are upheld.

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)