

Notice of Independent Review Decision

DATE OF REVIEW: 10/31/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

OP: Right SI Joint Injection 27096, 77003

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

The TMF physician reviewer board is certified in anesthesia and pain management with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

It is determined that the OP: Right SI Joint Injection 27096, 77003 is not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 10/24/12
- Decision letter– 09/12/12, 10/08/12
- Letter to TMF– 10/25/12
- Report of x-rays of the lumbar spine – 08/03/12
- Report of lumbar myelogram and post myelogram CT scan – 07/20/12
- Office visit notes by Dr. – 12/08/05 to 10/18/12
- Operative Report by Dr. – 04/10/12
- Plan of Care from Physical Therapy – 06/30/11,08/11/11
- Daily Notes by Select Physical Therapy – 07/25/11
- Copy ODG Treatment Integrated Treatment/Disability Duration Guidelines, Hip & Pelvis (Acute and Chronic) – 08/16/12

PATIENT CLINICAL HISTORY [SUMMARY]:

This injured worker sustained a work related injury on xx/xx/xx when he was lifting. This resulted in injury to his lower back. The office visit notes of 10/18/2012 describe the patient as having complaints of chronic sharp pain in his lower back with radiation into his right hip. He has been treated with medications, physical therapy and caudal epidural steroid injections at L3-4 and L4-5. There is a request for the patient to undergo OP: Right SI Joint Injection 27096, 77003.

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

The treating physician has not documented 3 positive signs of S1 dysfunction. The office visit notes of 10/18/12 by Dr. indicate no signs of S1 joint pathology. The ODG guidelines have not been met for the S1 joint injection.

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
- 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)