Pure Resolutions LLC

An Independent Review Organization
990 Hwy 287 N. Ste. 106 PMB 133
Mansfield, TX 76063
Phone: (817) 405-0870
Fax: (512) 597-0650
Email: manager@pureresolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

Amended 11/8/12
Date notice sent to all parties: Oct/17/2012

DATE NOTICE SENT TO ALL PARTIES:
Nov/8/2012

IRO CASE #:

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

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Orthopedic spine surgeon, practicing neurosurgeon

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)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
ODG - Official Disability Guidelines & Treatment Guidelines
Cover sheet and working documents
MRI lumbar spine without contrast dated 08/16/10
Operative report dated 11/10/10
Operative report dated 12/20/10
Operative report dated 01/21/11
Operative report dated 02/28/11
Discharge report from physical therapy dated 04/01/11
Office visit notes Dr. dated 06/15/11-08/01/12
Operative report dated 07/21/11
Utilization review determination dated 08/15/12
Reconsideration request dated 09/06/12

Preauthorization peer review form dated 09/18/12
Utilization review determination dated 09/18/12

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a female whose date of injury is xx/xx/xx. The records indicate that she was lifting a file off a top shelf and pulling it down when she felt a pull in her left lower back. MRI of the lumbar spine on 08/16/10 revealed a mild disc desiccation at L4-5; mild broad-based disc bulge at L4-5 with very mild bilateral foraminal narrowing; no disc extrusion or disc protrusion; no spinal stenosis. Records indicate that the claimant was treated conservatively with physical therapy, medications, epidural steroid injections, SI joint injections, and bilateral SI joint rhizotomy. The claimant was seen on 08/01/12 regarding her back and SI joint pain. It was noted that she was still having severe pain 7/10 over the SI joint. She reports 100% low back pain and no radiating leg pain. Pain is worse on the left but to a lesser degree on the right. She continues to work and take over-the-counter medications. Examination reported normal gait pattern. Claimant was able to heel-to-toe walk without difficulty. Lumbar spine exam noted severe tenderness over the SI joint bilaterally, worse on the left than the right. There was pain with compression of the joint. Claimant has positive thigh compression test as well. She has positive Gaenslen's on the left, mildly positive on the right. She was able to forward flex to 30-40 degrees, extend to 5-10 degrees and rotate and side bend 5-10 degrees. Neurological examination reported negative straight leg raise and negative indirect straight leg raise. Deep tendon reflexes were 2+ at the bilateral knees and ankles. Sensation to light touch was intact and symmetrical. There was no ankle clonus and negative Babinski sign. Strength was 5/5 throughout the bilateral lower extremities. Claimant was recommended to proceed with left SI joint fusion as she had failed extensive conservative treatment including physical therapy, SI joint injections, and rhizotomy to the SI joint.

A pre-authorization request for left SI joint fusion was non-authorized per review dated 08/15/12. The reviewer noted that ODGs do not recommend SI joint fusion except as a last resort as more high-quality studies need to be conducted to determine long-term safety and effectiveness.

An appeal request for left SI joint fusion was not authorized per review dated 09/18/12. The reviewer again noted that SI joint fusion is not recommended per ODGs, except as a last resort. More high-quality studies need to be conducted to determine long-term safety and effectiveness.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:
Based on the clinical information provided, the proposed left SI joint fusion is not supported as medically necessary. The claimant reportedly sustained an injury to the left low back on xx/xx/xx. She was treated conservatively with physical therapy, medications, bilateral SI joint injections, epidural steroid injections, and SI joint rhizotomy. She continued to complain of low back pain, with no radicular symptoms. Current evidence based guidelines do not support the use of sacroiliac joint fusion except as a last resort for chronic or severe SI joint pain. Indications for SI joint fusion require failure of non-operative treatment; chronic pain lasting for years; diagnosis confirmed by pain relief with intraarticular SI joint injections. This is an injury that occurred approximately 6 months ago. There is no indication that the claimant has reasonably completed all lower levels of care to include chronic pain management or IDDS consideration. Additionally given the claimant's limited response to other sacroiliac joint treatments, the efficacy of sacroiliac joint fusion at this juncture is unclear. As such, medical necessity is not established and the prior denials are upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE

WITH ACCEPTED MEDICAL STANDARDS

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES