

# Independent Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:**

Aug/23/2012

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Outpatient Sacroiliac Joint Left Injection

**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:

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 each health care service in dispute.**

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

ODG - Official Disability Guidelines & Treatment Guidelines

Employer's first report of injury or illness

Clinic notes 03/21/06

CT lumbar spine dated 09/08/06

Radiographic report lumbar spine 05/29/07

Clinic notes 12/13/10-06/25/12

Notice of dispute dated 03/10/06 and 07/26/11

Peer review dated 07/26/11 and 06/27/12

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a female who sustained an injury when she twisted her low back. The patient is status post lumbar fusion at L3-4 with continued significant degenerative disc disease at L4-5 and L5-S1. The patient did undergo spinal cord stimulator trial and permanent implantation that did provide some functional benefits from the patient's lower extremity pain. The patient also continued to take Celebrex and Tramadol. Clinical evaluation on 01/23/12

stated the patient's pain was increased with activities, and the patient reported Celebrex and Tramadol were not controlling her left sided pain. Physical examination revealed point tenderness over the left sacroiliac joint and positive Faber's sign was noted. The patient demonstrated antalgic gait and there was loss of lumbar range of motion. The patient was prescribed Ultram and given refills for Celebrex and left sacroiliac joint steroid injection was recommended. On 06/25/12 the claimant reported left sacroiliac joint pain. The claimant stated Celebrex and Ultram control her pain to some extent. Physical examination revealed a positive left sided Faber's test and positive compression test, thrust test, and loss of range of motion of lumbar spine was present. The claimant was continued on medications at this visit. A peer review from 06/27/12 stated the patient was recommended to continue with NSAIDs without other recommendations noted.

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

The request for left sacroiliac joint block would not be considered medically necessary based on clinical documentation submitted for review and current evidence based guidelines. The claimant has objective findings consistent with sacroiliac joint dysfunction; however, the clinic notes do not establish the patient has attempted any recent conservative treatment such as physical therapy or home exercise program. Additionally, the clinical documentation does not establish the requested blocks were to be performed under fluoroscope as indicated by current evidence based guidelines. Given the lack of clinical documentation to establish the claimant has reasonably exhausted physical therapy or home exercise program and as the clinical documentation does not indicate blocks will be performed under fluoroscopy, medical necessity is not established at this time and prior denials 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)