



# INDEPENDENT REVIEW INCORPORATED

Notice of Independent Review

**DATE NOTICE SENT TO ALL PARTIES: 12.04.13**

**IRO CASE #:**

**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 and treatment of patients suffering chronic low back pain and extremity pain.

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

Sacroiliac joint injection with fluoroscopic control

**REVIEW OUTCOME:**

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld** (Agree)
- Overtured** (Disagree)
- Partially Overtured** (Agree in part/Disagree in part)

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overtured</i>
724.6 724.6	77003 27096		Prosp. Prosp.				Xx/xx/xx Xx/xx/xx		Upheld Upheld

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

1. Independent Review forms.
2. referral forms.
3. Certificate independence of the reviewer.
4. Certification of eligibility of the reviewer.
5. denial letter, 09/23/13
6. denial letter, 10/21/13
7. denial letter, 11/04/13
8. Clinical records, Orthopedics (211 pages) with eighteen entries between 10/10/11 and 11/19/13.
9. Lumbar manual muscle strength examinations, eight entries between 01/13/12 and 10/29/13.
10. MRI scans of the lumbosacral spine, 06/04/13, 04/03/12, and 01/15/10, revealing degenerative disc disease, facet arthropathy, and evidence of spinal fusion.
11. Procedure orders, SI joint injection, 09/18/13, with preauthorization request.
12. Multiple faxed cover sheets.
14. denial letter, 04/22/13, neurosurgical evaluation,
15. certification letter, electrodiagnostic studies, 07/31/12,
16. letter acknowledging request for reconsideration, 10/15/13.
17. Letter of medical necessity, 09/18/13.
18. Faxes, 07/01/13 and 04/19/13.
19. Comprehensive clinical assessment, 12/14/12.
20. \_\_\_\_\_ panel, 06/13/13.
21. neurosurgeon, 06/14/12 and 05/17/12.

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22. 05/17/12.
23. Functional Restoration Services, 08/30/11.
24. four clinical entries between 10/08/05 and \_\_\_\_\_ 11/06.
25. EMG/NCV study, 11 \_\_\_\_\_ **(cuts out)**.
26. letter, approval of MRI scan of lumbosacral spine, 03/19/12, **RN**, MRI scan order.
27. letter, denial of EMG/NCV study, 01/18/12, denial of myelogram post CT scan, 11/28/11.
28. MRI and Diagnostics, order for CT myelogram.
29. X-ray report, 10/10/11.
30. Lumbar x-ray, 01/15/10.
31. DWC073 form, undated, ten entries between 10/10/11 and 03/07/13.
32. EMG/NCV request, undated.
33. Operative report, 03/29/06, removal of spinal instrumentation, exploration of fusion, L4 to the sacrum, MD.
34. Problem list, Orthopedics.

**PATIENT CLINICAL HISTORY (SUMMARY):**

The injured employee is a male who suffered a lumbosacral spine injury on xx/xx/xx. He has undergone multiple spinal surgeries, including discectomies and fusion from L4 through the sacrum. He has had exploration of the fusion mass, surgery at L2/L3, and exploration for pseudo meningocele. He has been treated with medications, including Ambien, Lyrica, Flexeril, Norco, Thera-Gesic cream, and omeprazole. His recent evaluations have \_\_\_\_\_ **(cuts out)** possible pain generator \_\_\_\_\_ sacroiliac joints. A request to perform intraarticular sacroiliac injections with fluoroscopic control has been considered and denied. It was reconsidered and denied.

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

The diagnosis of sacroiliac dysfunction and the sacroiliac joint as a pain generator is somewhat difficult. The only tests of sacroiliac joint function documented at this time are Fabere tests and distraction tests. It would appear that this is insufficient to justify intraarticular injections at this time. The prior denial of the request to perform injections under fluoroscopic control of the sacroiliac joints was 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
- Medical judgment, clinical experience and expertise in accordance with accepted medical standards
- \_\_\_\_ Mercy Center Consensus Conference Guidelines
- \_\_\_\_ Milliman Care Guidelines
- ODG-Office 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)