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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Nov/20/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: injection procedure for sacroiliac joint, anesthetic steroid with image guidance (fluoroscopy or CT) including arthrography when performed

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Neurological Surgery

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. It is the opinion of this reviewer that the request for injection procedure for sacroiliac joint, anesthetic steroid with image guidance (fluoroscopy or CT) including arthrography when performed is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Clinical notes 09/26/12
Clinical notes 01/16/12
MRI lumbar spine 01/25/12
Clinical notes 02/16/12
Clinical notes 11/15/12
Procedure note 04/12/13
Clinical notes 03/05/13
Clinical notes 05/14/13
Clinical notes 07/23/13
Operative note 07/10/13
Clinical notes 08/27/13
Clinical notes 10/01/13
Prior utilization review 11/28/12
Prior utilization review 03/25/13
Prior utilization review 09/20/13
Prior utilization review 10/14/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who reported an injury to his low back and hips. Clinical note dated 01/16/13 indicated the patient stating initial injury occurred when he fell sustained a direct trauma to the right side of the pelvis resulting in low back pain radiating into the right side of the groin. The patient underwent therapy and medications addressing ongoing complaints of pain. Upon exam the patient demonstrated 45

degrees of lumbar flexion. Tenderness was noted throughout the paraspinal musculature. Pain was noted with straight leg raise on the right. Strength was 4/5 at the right extensor halluc longus. Reflexes were depressed at the ankles. The MRI of the lumbar spine dated 01/25/12 revealed disc herniation at L5-S1. Posterior protrusion was also noted at L3-4 and L4-5. Clinical note dated 09/26/12 indicated the patient continuing with complaints of low back pain rated as 5-7/10. Pain radiated from the low back into the lower extremities. The procedure note dated 04/12/13 indicated the patient undergoing medial branch blocks at L4, L5, and S1. Clinical note dated 11/15/12 indicated the patient indicated the patient undergoing two lumbar epidural steroid injections and right shoulder corticosteroid injection. The patient rated low back pain as 8/10.

Clinical note dated 05/14/13 indicated the patient continuing with complaints of low back pain radiating into the lower extremities. Previous medial branch block reduced pain from 8/10 to 3/10. However, the patient noted a return to pain along with strength deficits. The operative report dated 07/10/13 indicated the patient undergoing radiofrequency ablation at L4, L5, and S1. Clinical note dated 07/23/13 indicated the patient complaining of low back pain described as tingling and burning sensation. Numbness was noted in the left lower extremity. The patient was recommended to initiate physical therapy. Clinical note dated 08/27/13 indicated the patient undergoing home therapy program. The patient had a history of right shoulder pain. Clinical note dated 10/01/13 indicated the patient complaining of tingling sensation following the recent radiofrequency ablation. Utilization review dated 09/20/13 resulted in denial for sacroiliac joint injection as no indication the patient had failed a course of conservative treatment for four to six weeks was mentioned in the clinical notes. Utilization review dated 10/14/13 resulted in denial for sacroiliac joint injection as no information was submitted confirming sacroiliac joint involvement by clinical evaluation and no documentation was submitted confirming completion of recent physical therapy.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: Clinical documentation submitted for review notes the patient complaining of low back pain. Sacroiliac joint injection with fluoroscopic guidance would be indicated provided that the patient meets specific criteria, including completion of a four to six week course of conservative treatment addressing the specific low back complaints. No information was submitted regarding recent involvement with conservative treatment. As such, it is the opinion of this reviewer that the request for injection procedure for sacroiliac joint, anesthetic steroid with image guidance (fluoroscopy or CT) including arthrography when performed is not recommended as medically necessary.

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)