

Notice of Independent Review Decision

**DATE OF REVIEW:** 10/10/2013

**IRO CASE #:**

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

Arthrodesis, sacroiliac joint (including obtaining graft)

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

The TMF physician reviewer is a board certified orthopedic surgeon 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 arthrodesis, sacroiliac joint (including obtaining graft) 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 – 09/27/13
- Decision letter – 08/29/08, 12/07/09, 12/07/12, 08/21/13, 08/23/13
- Review – 10/26/12, 08/12/13, 08/23/13
- Pre-authorization request form – no date
- Office Visit Notes – 01/25/13 to 07/24/13
- Operative Report – 09/22/08, 01/20/10, 02/16/12, 07/11/13

- Report of myelogram of the lumbar spine – 12/28/10
- Report of post-myelogram CT scan of the lumbar spine – 12/28/10
- Approval of request for sacroiliac joint injection – 06/04/13
- Results of pre-authorization for purchase of TENS unit – 11/09/12
- Disability evaluation – 09/28/10
- Operative Report – 09/22/08
- Request for reconsideration – 08/20/13

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient suffered a lumbar strain type injury on xx/xx/xx. She has undergone a number of lumbar surgical procedures including fusion at L4-L5 and L5-S1. She suffers persistent pain and is now suffering sacroiliac joint pain. She has positive FABER test and tenderness. She has undergone sacroiliac joint injections with very short duration of relief. The current request is for preauthorization of sacroiliac joint fusion.

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

The extent to which the sacroiliac joint pain interferes with this patient's activities of daily living has not been documented. Specific chronic pain management consultation and treatment has not been documented. The medical necessity for arthrodesis, sacroiliac joint (including obtaining graft) has not been established.

**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)