



Notice of Independent Review

REVIEWER'S REPORT

DATE NOTICE SENT TO ALL PARTIES: 02/04/13

IRO CASE #:

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

Texas-licensed M.D., board certified in Anesthesiology, added qualifications in Pain Medicine

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Bilateral SI joint injection #2.

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 Overturn</i>
			<i>Prosp.</i>				<i>Xx/xx/xx</i>	<i>12233427</i>	<i>Upheld</i>

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

1. TDI case assignment.
2. Letters of denial 12/26/12 and 01/14/13, including criteria used in the denial.
3. PM&R evaluation/follow up 11/26/12 and 12/17/12.
4. Operative report joint injections 11/02/12.
5. Nerve studies 08/09/12.
6. Radiology reports 05/15/12 (L spine – 3 views) and 05/18/12 (MRI lumbar spine).
7. Peer review report 06/14/12
8. Treating doctor's evaluation 08/09/12
9. Lab report 07/12/12
10. Office visits – unidentified provider – pain management 05/02/12 – 08/14/12.

PATIENT CLINICAL HISTORY (SUMMARY):

This individual sustained a back injury on xx/xx/xx. A bilateral sacroiliac joint injection was performed on 11/02/12. At the 12/17/12 office visit, improvement was described but not quantitated, and the trochanteric bursa was injected. Previous reviewers have cited lack of evidence of SI joint dysfunction, namely lack of three physical findings, and lack of quantization of relief from the first injection.

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

Official Disability Guidelines require 70% pain relief for six weeks after the first SI joint injection to approve a second one. There is lack of documentation of duration and percentage of relief after the procedure. ODG are not met for the requested procedure.



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)