

# Independent Resolutions Inc.

An Independent Review Organization  
835 E. Lamar Blvd. #394  
Arlington, TX 76011  
Phone: (817) 349-6420  
Fax: (817) 549-0311  
Email: rm@independentresolutions.com

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:**

Jan/24/2013

**IRO CASE #:**

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

Outpatient Left SI Joint Injection

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

PM&R and Pain Medicine

**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

Utilization review determination dated 12/13/12, 12/31/12

Office visit note dated 01/08/13, 11/29/12, 11/02/12, 08/13/12, 06/29/12, 05/25/12, 04/06/12, 12/01/11, 10/24/11, 09/12/11, 08/26/11, 08/12/11, 07/28/11, 06/03/11, 07/20/09, 06/08/09, 05/11/09, 03/23/09, 08/21/08, 07/31/08, 07/11/08, 06/09/08, 04/24/08, 01/25/08, 09/13/07, 07/05/07, 05/25/07, 10/06/06, 09/25/06, 08/31/06, 06/29/06, 06/23/06, 05/12/06, 05/03/06, 03/27/06, 03/06/06, 02/28/06

Letter dated 01/15/13

Lumbar discogram dated 07/07/06

CT myelogram dated 06/22/07

EMG/NCV dated 08/11/08

MRI lumbar spine dated 08/02/11, 03/31/06

Operative report dated 05/09/12, 08/30/11, 08/22/11, 04/09/08, 09/19/06, 05/26/06

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male whose date of injury is xx/xx/xx. On this date the patient was lifting and pushing boxes and felt a pull to his back. The patient's surgical history is significant for previous L4-5 fusion in 2004. Treatment to date includes epidural steroid injection x 3 in 2006, sacroiliac joint injection on the left on 09/19/06 which did not give him any significant improvement, left sided decompression L3-4 with partial laminectomy and partial medial facetectomy on 04/09/08, L4 SNRB on 05/26/09, L5-S1 facet joint injections in July 2011 with no improvement, right transforaminal epidural steroid injection at L3-4 on 08/22/11, repeat left

sided decompression at L3-4 with partial laminectomy and partial medial facetectomy as well as right sided decompression L3-4 with partial laminectomy, partial medial facetectomy and partial foraminotomy on 08/30/11 and radical anterior discectomy L5-S1 with fusion on 05/09/12. EMG/NCV dated 08/11/08 revealed electrodiagnostic evidence of an acute on chronic left L5-S1 radiculopathy with signs of active denervation on needle exam. The patient was determined to have reached maximum medical improvement as of 08/21/08 with 10% whole person impairment. Follow up note dated 11/02/12 indicates that the patient complains of left sided low back pain with occasional pain to the right as well. On physical examination there are no focal deficits. Sensation is intact with normal reflexes, coordination, muscle strength and tone. Fabere test is positive to the left. Straight leg raising is negative bilaterally. Note dated 11/29/12 indicates Faber's is positive on the left. There is no SI joint tenderness appreciated.

Initial request for outpatient left SI joint injection was non-certified on 12/13/12 noting that it is unclear if the patient has had any recent optimization of conservative treatment including physical therapy. Furthermore, the patient does not satisfy the diagnostic criteria for the left SI joint injection as indicated by the ODG. Given the patient's persistent radicular symptoms the necessity and benefits of the left SI joint injection is questionable. The denial was upheld on appeal dated 12/31/12 noting that there remains no documentation of the diagnostic criteria for a sacroiliac joint injection as indicated in the guidelines including at least two more positive examination findings. Follow up note dated 01/08/13 indicates that no SI joint tenderness was appreciated. Faber's and Stork test are positive on the left.

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

Based on the clinical information provided, the request for outpatient left SI joint injection is not recommended as medically necessary, and the two previous denials are upheld. The submitted records document only two positive exam findings, Faber's and Stork tests. The Official Disability Guidelines require documentation of at least 3 positive exam findings. ODG also requires that the patient has had and failed at least 4-6 weeks of aggressive conservative therapy including physical therapy, home exercise program and medication management. The patient is noted to be status post radical anterior discectomy L5-S1 with fusion on 05/09/12; however, there is no comprehensive assessment of postoperative treatment completed to date or the patient's response thereto submitted for review. It is unclear whether the patient has undergone any recent active treatment to include physical therapy and/or a home exercise program. Carrier records indicate that to date no physical therapy has been requested or documented as completed. Given the current clinical data, the requested SI joint injection is not indicated as medically necessary.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

**MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

**ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**