IMedReviews
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Notice of Independent Review Decision

**DATE OF REVIEW:** 12/31/2012

**IRO CASE #**

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

In office sacroiliac (SI) joint/posterior sacroiliac ligament left injection.

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

D.O. Board Certified in Anesthesiology and Pain Management.

**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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

| Document Type | Date(s) - Month/Day/Year |
|---|---|
| Texas Department of Insurance<br>Notice of Case Assignment | 12/11/2012 |
| Utilization Management Decisions<br>Prospective IRO Review Response<br>Requests for Pre-Authorization | 11/01/2012-11/30/2012<br>12/11/2012<br>08/24/2012-10/26/2012 |
| Pain Consultants, LLC<br>Requests for Pre-Authorization<br>Request Reconsideration<br>Radiological Review<br>Clinical Assessment | 8/23/2012-10/26/2012<br>11/21/2012<br>08/19/2012<br>08/19/2012 |

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| Follow- Up Notes | 10/08/2012-11/19/2012 |
| Hospital<br>Radiology Report | 7/10/2012 |
| Association<br>M.D. | 2/19/2008 |
| M.D.<br>Office Visit Note | 08/13/2012 |
| Texas Workers' compensation<br>Work Status Report | 11/19/2012 |
| Medical & Family<br>Progress Note | 10/22/2012 |

## PATIENT CLINICAL HISTORY [SUMMARY]:

Patient is a female who fell down a flight of stairs while at work on xx/xx/xx. Patient presented with a compensable injury to the neck and back. She underwent conservative treatment to include chiropractic, physical therapy, diagnostic studies, epidural steroid injections in both lumbar and cervical spine, and oral medications including: Tramadol, Gabapentin, and Skelaxin. Patient reported good relief from lumbar TF epidural steroid injection at L5-S1, no documentation on the relief from the cervical TF at C5-6 was documented. On 10/22/2012 during an evaluation, it was reported that the patient's symptoms in regard to her low back have worsened, complaints of moderately severe pain across her lumbar spine and the pain radiating down to her left knee. Patient did have positive findings on multiple exams for left sacroiliitis (compression test, sacral thrust, Faber test, Stinchfield maneuver, Scour maneuver). Patient also had good strength in all muscle groups 5/5 on physical exam except for the left 4/5 of the dorsiflexion, plantar flexors, and extensor hallucis longus. Sensation was decreased on the left in S1 distribution.

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

Per ODG references the requested Sacroiliac (SI) joint/ posterior sacroiliac ligament left injection is medically necessary. After reviewing the documentation provided, the patient does have all the indications for left sacroiliitis on physical exam, she did undergo conservative treatment to include oral medications, chiropractic treatment and physical therapy. Although the physical therapy was not specific to the area of the SI joint when it was first started but it was resumed in the last note by Dr. on November 19/2012, with more emphasis on the neck and lumbosacral area. Therefore, a left SI joint injection is medically necessary.

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## 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 KNOWLEDGE BASE
- ☐ 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