

Parker Healthcare Management Organization, Inc.

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Notice of Independent Review Decision

DATE OF REVIEW: JANUARY 9, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of the proposed bilateral Sacroiliac joint Injection w/ Fluroscopy (27096 X2, 77003)

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in orthopedic surgery and is engaged in the full time practice of medicine.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- XX Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
724.4	27096		prosp	2			Xx/xx/xx	877912	upheld
724.4	77003		prosp	1			Xx/xx/xx	877912	upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI-HWCN-Request for an IRO-18 pages

Respondent records- a total of 41 pages of records received to include but not limited to: TDI letter 12.20.12; letter 10.9.12, 11.2.12, 11.9.12; IRo request forms; records, 10.8.12; Pre-Auth forms 10.3.12, 10.17.12; records 9.25.12; report 11.2.12; 7.25.12, 9.4.12; MRI Lumbar Spine

Requestor records- a total of 0 pages of records received to include but not limited to: 12.21.12 sent request for records to all; 12.30.12 sent 2nd request for records to 12.31.12 left message

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient sustained a work related injury on xx/xx/xx.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

The denial is upheld. Sacroiliac joint blocks are recommended as an option if failed at least 4-6 weeks of aggressive conservative therapy. There is no documentation submitted to support evidence of aggressive conservative therapy.

This patient has chronic low back pain. Sacroiliac joint injections are not recommended for treatment of acute low back pain including low back pain thought to be sacroiliac joint related; subacute or chronic non-specific low back pain, including pain attributed to sacroiliac joints, but without evidence of inflammatory sacroiliitis (rheumatologic disease). They are not recommended for acute, sub-acute and chronic radicular pain syndromes (insufficient evidence). Sacroiliac joint injections are not recommended for treatment of any radicular pain syndrome. This patient has evidence of chronic radicular pain syndrome. References: ODG. ACOEM Practice Guidelines

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

XX ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL
MEDICINE UM KNOWLEDGEBASE

XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

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

XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES