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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jul/23/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: right SI joint injection

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O., Board Certified Physical Medicine and Rehabilitation 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. It is the opinion of the reviewer that the request for right SI joint injection is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Utilization review determination dated 05/17/13, 06/05/13
Office note dated 05/28/13, 05/09/13, 04/11/13, 03/29/13, 03/04/13, 02/20/13, 01/18/13, 12/10/12, 11/02/12, 10/19/12, 10/05/12, 11/23/11
Treatment note dated 02/14/13, 02/12/13, 02/06/13, 01/24/13, 01/22/13, 01/16/13, 01/09/13, 01/08/13, 12/20/12
FAB questionnaire dated 12/20/12
Oswestry low back pain scale dated 12/20/12
MRI of the lumbar spine dated 02/27/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female whose date of injury is xx/xx/xx. Note dated 11/23/11 indicates that the patient has a history of prior injury with low back pain beginning in xxxx while lifting a water cooler. The patient underwent right L5 and S1 epidural steroid injection on 10/19/12 with 95% improvement. Per note dated 12/10/12, the patient sustained injury on xx/xx/xx after breaking up a fight, she fell. The patient subsequently underwent a course of physical therapy. MRI of the lumbar spine dated 02/27/13 revealed disc bulge and spondylosis at L5-S1 particularly on the left with mild to moderate compromise of the left neural foramen; disc bulges at L3-4 and L4-5; small lateral annular tear on the left at L2-3; no evidence of neural impingement. The patient underwent right L5 and S1 epidural steroid injection on 03/29/13 and reported 85% overall improvement. The most recent note dated 05/28/13 indicates that pain is rated as 6/10. On physical examination there is a positive Fortin finger sign over the right SI joint. She is exquisitely tender to palpation over the right SI joint. Faber is positive on the right.

Initial request was non-certified on 05/17/13 noting that medical documentation offers virtually no physical examination to support the possibility that there is a sacroiliac issue here. The

ODG criteria for consideration of the requested procedure is not met. The denial was upheld on appeal dated 06/05/13 noting that if the patient received 85% relief short term with epidural steroid injection as reported in the 04/11/13 note, there is no reasonable expectation that some other injection to address another pain generator will provide any significant relief.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient underwent lumbar epidural steroid injection at L5-S1 on 03/29/13 and reported 85% overall improvement on follow up evaluation. Additionally, note dated 05/09/13 indicates that right L5-S1 facet injection might also be indicated. The Official Disability Guidelines report that diagnostic evaluation must first address any other possible pain generators. Given the patient's significant response to prior epidural steroid injection and consideration of lumbar facet injections, ODG criteria for performance of a sacroiliac joint injection are not met. As such, it is the opinion of the reviewer that the request for right SI joint injection is not recommended as medically necessary.

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

ACOEM-AMERICA 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)