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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: July 12, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Bilateral sacroiliac joint injections with fluoroscopy.

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

M.D., Board Certified in Anesthesiology 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)

I have determined that the requested bilateral sacroiliac joint injections with fluoroscopy are not medically necessary for treatment of the patient's medical condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization dated 6/18/13.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 6/21/13.
3. Notice of Assignment of Independent Review Organization dated 6/24/13.
4. Denial documentation dated 3/22/13 and 5/8/13.
5. MRI of Lumbar Spine dated 2/19/13.
6. Clinic notes dated 3/5/13.
7. Clinic notes dated 2/13/13, 2/21/13, 4/10/13, 4/24/13 and 6/12/13.

8. Clinic notes dated 3/5/13.
9. Clinic notes dated 4/3/13 and 4/5/13.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained a work related injury to his lower back on xx/xx/xx. The patient was initially seen on 2/13/13 and was noted to have a history of symptoms for years with the original injury being a lifting injury. The patient reported low back pain, left greater than right with some radiation to the left thigh and pain level at 6/10. Upon examination, the patient had left buttock pain with left straight leg raise and restricted range of motion. An MRI of the lumbar spine dated 2/19/13 revealed findings of moderate decreased disc height at L2-3 with small circumferential annular bulge and no stenosis. The patient had slight decreased disc height as L5-S1 with small circumferential annular bulge and moderate left foraminal stenosis. A follow-up visit on 3/5/13 indicated that the patient reported 4/10 to 5/10 average pain in the axial low back. The note also indicated that the patient had been treated with physical therapy in 2011 without relief and injections with temporary relief. On examination, the patient was noted to have tenderness to palpation along the bilateral sacroiliac region. The patient was recommended for bilateral sacroiliac (SI) joint injection, as well as consideration for lumbar epidural steroid injection and/or lumbar discogram. On 4/10/13 a clinical note reported the patient continued to report pain at 6/10 to 7/10. The note indicated the patient was unable to work and had been taking Norco with some moderate relief. The patient had completed three sessions of physical therapy without significant improvement. A follow-up note on 6/12/13 reported the patient had continued pain with some radiation to the left thigh. The patient was also noted to have limited range of motion and was recommended for disability. A request has been made for authorization of bilateral sacroiliac (SI) joint injections with fluoroscopy.

The URA indicated that the patient did not meet Official Disability Guidelines (ODG) criteria for the requested services. Specifically, the URA's initial denial stated that ODG guidelines do not support the bilateral SI joint injections as the patient has not exhausted conservative care to include physical therapy. On 5/8/13, the URA reported that the request was again non-certified based on ODG guidelines as the patient had undergone previous injections with no long-term benefit and there was also a lack of physical exam findings to support the need for SI joint injections.

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

In this patient's case, Official Disability Guidelines (ODG) do not support the requested bilateral SI joint injections with fluoroscopy. Official Disability Guidelines state that SI joint injections are recommended for patients with a history and physical suggestive of a diagnosis with documentation of at least three positive exam findings. The patient was noted to have positive tenderness to palpation; however, there was a lack of three positive orthopedic exam findings to support a diagnosis of SI joint dysfunction. There was also a lack of documentation of at least 4 to 6 weeks of aggressive conservative therapy, including physical therapy as recommended by ODG. The patient was reported to have only completed 3 sessions of physical therapy. In addition, there is a lack of documentation clarifying which injections the patient has previously undergone. ODG only recommend repeat injections when there is at least six weeks of greater

than 70% pain relief. The medical records indicate that the prior injections provided no long-term benefit. Moreover, the updated clinical notes did not address the prior concerns of the two previous denials. Therefore, given the lack of support by Official Disability Guidelines, the requested service is not medically necessary.

In conclusion, I have determined the requested bilateral sacroiliac joint injections with fluoroscopy are not medically necessary for treatment of the patient's medical condition.

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- 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)