



Notice of Independent Review Decision - WC

IRO REVIEWER REPORT – WC

DATE OF REVIEW:

06/20/13

DATE OF AMENDED REVIEW:

07/01/13

IRO CASE #:

46142

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

STAT OP Left SI Joint Injection (PNR Fluoro Guidance)

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

Board Certified in Physical Medicine & Rehabilitation

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 or not medical necessity exists for each of the health care services in dispute.

STAT OP Left SI Joint Injection (PNR Fluoro Guidance) - UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Physician Documentation, 01/24/13
- Lumbar Spine MRI, 02/14/13
- Office Visit, 03/05/13, 04/02/13, 04/16/13, 04/18/13, 04/30/13, 05/28/13
- Electrodiagnostic Study, 03/26/13
- Operative Report, 04/03/13, 04/22/13
- Denial Letter, 05/03/13, 05/23/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The records available for review indicated that on xx/xx/xx, the patient received an evaluation. On this date it was documented that the patient was with symptoms of low back pain with radiation to the left lower extremity. The patient was diagnosed with sciatica. The patient was provided a prescription for Norco and Flexeril.

A lumbar MRI scan was obtained on 02/14/13. By report this study disclosed findings consistent with the presence of disc desiccation at the L3/L4, L4/L5, and L5/S1 levels. The report did not describe findings definitively consistent with the presence of a compressive lesion upon a neural element in the lumbar spine.

The patient was evaluated on 03/05/13. On this date the patient was with pain symptoms referable to the low back region and the left lower extremity. The pain was described as six on a scale of one to ten. This physician documented that the patient was with a medical diagnosis of lumbosacral radiculitis. It was recommended that an electrodiagnostic assessment of the left lower extremity be accomplished.

An electrodiagnostic assessment of the left lower extremity was obtained on 03/26/13. This study disclosed findings consistent with the presence of a chronic lumbosacral radiculopathy affecting predominantly the left L5 nerve root. It was documented that an associated polyneuropathy could not be ruled out.

The patient was evaluated on 04/02/13. It was documented that the patient was with symptoms of pain described as a five on a scale of one to ten.

On 04/03/13 the patient underwent a lumbar transforaminal epidural steroid injection to the left L5/S1 level. This procedure was performed.

The patient was re-evaluated on 04/16/13. It was documented that the patient received a 20% reduction in pain symptoms from the procedure accomplished on 04/03/13.

assessed the patient on 04/18/13. On this date it was recommended that the patient undergo treatment in the form of a lumbar epidural steroid injection in an effort to obtain a reduction in pain symptoms.

On 04/22/13 the patient underwent a lumbar epidural steroid injection to the L5/S1 level. This procedure was performed.

reassessment the patient on 04/30/13. It was documented that the patient was with a 60-70% reduction in pain symptoms with the recent treatment in the form of a lumbar epidural steroid injection. It was recommended that the patient undergo a left-sided sacroiliac joint injection as the claimant was with symptoms of persistent left-sided low back pain.

assessed the patient on 05/28/13. On this date the patient was with symptoms of low back pain described as ten on a scale of one to ten. There was documentation of pain symptoms in the low back region with radiation to the left thigh and calf region. There were symptoms of numbness and tingling, as well. It was recommended that the patient undergo treatment in the form of a left-sided sacroiliac joint injection.

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

Based upon the medical records presently available for review, Official Disability Guidelines would not presently support a medical necessity for treatment in the form of a left-sided sacroiliac joint injection. This reference would not support this specific request to be one of medical necessity due to the fact that there is documentation to indicate that there was a positive response to a past attempt at treatment in the form on lumbar epidural steroid injections. Such a response would support a medical diagnosis of a lumbar radiculopathy/radiculitis. Additionally, an electrodiagnostic assessment accomplished after the date of injury as documented above did reveal findings consistent with the presence of a lumbar radiculopathy. Hence, a medical necessity for left-sided sacroiliac joint injection is not established when there is documentation of signs of symptoms consistent with a lumbar radiculopathy confirmed by an electrodiagnostic assessment. Additionally, there are not sufficient documented physical examination findings to support a medical diagnosis of a sacroiliac joint pain mediated syndrome per criteria set forth by Official Disability Guidelines. The documented signs and symptoms as well as diagnostic test results appear to be consistent with a medical condition of a lumbar radiculitis/radiculopathy. Hence, for reasons as outlined above, Official Disability Guidelines would not support a medical necessity for treatment in the form of a left-sided sacroiliac joint injection in this particular case.

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**