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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Apr/02/2014

IRO CASE #:

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

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O., Board Certified Orthopedic Surgery

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 side SI joint injection is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female whose date of injury is xx/xx/xx. the mechanism of injury is not described. Follow up note dated 08/01/06 indicates that the patient's spinal cord stimulator is working extremely well. Follow up note dated 11/09/06 indicates that the patient finished the CoPE program about 6 months ago. Note dated 03/02/12 indicates that the patient has had SI injections which were helpful in the past. She feels like the SI has gone out again. The patient underwent bilateral sacroiliac joint block on 04/24/12. Follow up note dated 08/22/12 indicates that the patient underwent right knee replacement on 08/06/12. Follow up note dated 01/13/14 indicates that she has been feeling worse for the last 2 weeks. She is having right lumbar pain. The patient underwent IDET procedure years ago and a laminectomy/discectomy. On physical examination lumbar range of motion is painful. Straight leg raising is normal bilaterally. Lower extremity strength is symmetrically present. Left light touch is abnormal at L5 dermatomes. Fortin finger test is positive to the right and negative to the left. Yeoman's test is positive to the right and left. Faber test is positive bilaterally. Gaenslen's and femoral thrust are positive to the right.

Initial request for right side SI joint injection was non-certified on 01/23/14 noting that there should be documentation of a failure to respond to at least 4 to 6 weeks of aggressive conservative therapy. In the treatment or therapeutic phase, the suggested frequency for repeat blocks is 2 months or longer between each injection provided that at least greater than 70% pain relief is obtained for 6 weeks. The patient underwent bilateral sacroiliac joint injections on 04/24/12. Documentation of at least greater than 70% pain relief response was not provided. There is no evidence of a recent failure to respond to at least 4 to 6 weeks of aggressive conservative therapy including physical therapy, home exercise program and medication management. The denial was upheld on appeal dated 02/27/14 noting that the updated documentation was unable to sufficiently address the issues in the previous denial. Per ODG, repeat sacroiliac joint injections require at least greater than 70% pain relief lasting

for six weeks. The patient received bilateral sacroiliac joint injections on 04/24/12; per 08/22/12 report, injections made her pain worse.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient sustained injuries on xx/xx/xx. The patient underwent bilateral sacroiliac joint block on 04/24/12. The Official Disability Guidelines support repeat sacroiliac joint injection with evidence of at least 70% pain relief for at least 6 weeks. The patient's objective, functional response to prior sacroiliac joint injection is not documented. There is no indication that the patient has undergone any recent active treatment. As such, it is the opinion of the reviewer that the request for right side 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)