

INDEPENDENT REVIEW INCORPORATED

Notice of Independent Review

REVIEWER'S REPORT

DATE NOTICE SENT TO ALL PARTIES: 12.31.13

IRO CASE #:

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

M.D., F.A.C.S., board certified orthopedic surgeon with extensive experience in the evaluation of patients suffering low back pain and radiating lower extremity pain

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Sacroiliac joint injection, right side, with sedation

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)

Primary Diagnosis Code	Service Being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	OWE Claim#	Upheld Overturn
724.6	27096		Prosp.				Xx/xx/xx		Upheld
724.6	77003		Prosp.				Xx/xx/xx		Upheld
724.6	99144		Prosp.				Xx/xx/xx		Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

1. Independent Review, Inc. forms
2. FAX cover requesting medical records
3. Back Institute, clinical note 11/04/13
4. Periodic outcomes evaluation, 11/04/13
5. Back pain questionnaire
6. MRJ scan of lumbosacral spine, 10/15/13, revealing L4-L5 and L5-S1 degenerative disc disease with levoscoliosis at L4-L5
7. Clinical progress note, 10/23/13
8. Adverse Determination Letter, II/22/13, with a reconsideration, 12/05/13

PATIENT CLINICAL HISTORY (SUMMARY):

The claimant suffered a fall. He has low back pain and pain which radiates into the proximal portion of his right lower extremity. He has been treated with nonsteroidal anti-inflammatory medication. The physical findings reveal diminished lumbar spine range of motion. There is no motor or sensory deficit. The claimant has received a recommendation for right-sided sacroiliac joint injection with sedation. The request for pre-authorization of such treatment was considered and denied. It was reconsidered denied.

INDEPENDENT REVIEW INCORPORATED



ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The claimant suffers primarily low back pain with diminished range of motion. He has radiographic evidence of degenerative disc disease. There is no documentation of positive tests of sacroiliac joint dysfunction. FABERE's test is not documented. Single-leg-standing pain is not documented. There is no documentation of physical therapy. It would appear that medical necessity for a right side sacroiliac joint injection with sedation has not been established. Adverse determination of a pre-authorization request for such treatment was appropriate and should be upheld.

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
- AHCPH-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-Office 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)