

US Decisions Inc.

An Independent Review Organization
8760 A Research Blvd #512
Austin, TX 78758
Phone: (512) 782-4560
Fax: (207) 470-1085
Email: manager@us-decisions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jun/17/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: SI joint injection series of two

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 SI joint injection series of two 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. MRI of the lumbar spine dated 02/22/13 revealed postsurgical changes at L4-5 and L5-S1 levels and posterior bulging disc at L1-2, L2-3 and L3-4. Handwritten note dated 05/15/14 indicates there is positive Yeoman's. Motor, sensory and deep tendon reflexes are normal in the lower extremities. Faber is positive bilaterally. Straight leg raising is negative bilaterally.

Initial request for SI joint injection series of two was non-certified on 04/22/14 noting that serial monthly office note documentation from this provider from 10/08/13 through 04/17/14 documents an absence of subjective complaints and examination findings supportive of SI joint mediated low back pain to support the requested injections. The denial was upheld on appeal dated 05/22/14 noting that there was no recent detailed physical examination provided that would indicate the necessary criteria required by the ODG indicative of sacroiliac joint dysfunction. There were no physical therapy notes provided that would indicate the amount of physical therapy visits the patient has completed to date and/or the patient's response to previous conservative treatment. There was no indication that the patient is actively participating in a home exercise program.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient's date of injury is xx/xx/xx; however, there is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. The Official Disability Guidelines require documentation of failure of aggressive conservative therapy. The patient's physical examination documents positive Faber and positive Yeoman's. The Official Disability

Guidelines require documentation of at least 3 positive exam findings. The request is excessive as subsequent blocks are only supported with positive response to prior injection. As such, it is the opinion of the reviewer that the request for SI joint injection series of two 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)