

P-IRO Inc.

An Independent Review Organization

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Case Number:

Date of Notice: 06/22/2015

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Orthopedic Surgery

Description of the service or services in dispute:

Left SI joint fusion

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)

Patient Clinical History (Summary)

is a male with complaints of pain. On 09/11/14, 09/18/14, 09/19/14, 09/22/14, he was seen in physical therapy. He returned on 12/29/14 for continued physical therapy. On 01/28/15, he was given a diagnostic sacroiliac joint injection under fluoroscopic guidance. On 02/12/15, he was given a left diagnostic and therapeutic sacroiliac joint injection with local anesthetic and steroids. On 04/16/15, plain x-rays of the lumbar spine revealed surgical changes at L4, L5, and S1. On 04/22/15, the patient returned to clinic with continued complaints of pain. He noted the left SI joint injection caused resolution of his pain almost entirely going down to 2/10 for 6 hours. On examination, his strength was 5/5, sensation was intact, and he had tenderness to the left SI joint. A left SI joint fusion was recommended.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

On 04/28/15, a peer review report was submitted for the requested left SI joint fusion. It was noted the fusion was not medically necessary at that time as the clinical documentation submitted did not note complete failure of conservative treatment or other levels of care. It was noted that this procedure is considered an option of last resort for years in chronic sacroiliac joint pain that has failed all reasonable methods of controlling pain. Noting minimal findings on physical examination and the lack of long term response to Corticosteroid injections in the left SI joint, the recommendation was for non-certification. On 05/07/15, a peer review for the requested left SI joint fusion noted that the requested procedure was not medically necessary as it is a procedure of last resort and the claimant's injury was only 9 months old and he had completed physical therapy with continued pain at 8/10 and per the physical therapy notes there is no SI joint dysfunction noted and the documentation did not indicate the patient is at the point of last resort. Therefore the request was non-certified. The records submitted for this review also note the patient has received 2 left SI joint injections on 01/28/15 and 02/12/15. While the provider notes the patient had resolution of his pain taking his pain down to 2/10 after the injections, there is still a clear lack of documentation of failure of all lesser measures. There is also a clear lack of documentation that the SI joint is the pain generator. The most recent exam fails to identify a positive finger Fortin test, or other positive orthopedic tests to indicate that the SI joint is the pain generator. Therefore, it is the opinion of this reviewer that the request for a left SI joint fusion is not medically necessary and the prior denials are upheld.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ACOEM-America College of Occupational and Environmental Medicine um
- knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- DWC-Division of Workers Compensation Policies and 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 and Treatment
- Guidelines Pressley Reed, the Medical Disability Advisor
- Texas Guidelines for Chiropractic Quality Assurance and Practice
- Parameters Texas TACADA Guidelines
- TMF Screening Criteria Manual
- Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
- Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)