



Notice of Independent Review Decision  
*CompPartners*

**DATE OF REVIEW:** 1/10/08

**NAME:**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Determine the medical appropriateness for the previously denied request for radiofrequency ablation (RFA) of the right sacroiliac joint, with fluoroscopy under anesthesia.

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

Texas Licensed Pain Management Specialist.

**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.

The previously denied request for RFA of the right sacroiliac joint, with fluoroscopy under anesthesia.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Notice to, Inc. of Case Assignment dated 11/14/07.
- Faxing Required Information dated 11/15/07.
- Sent Fax Details dated 11/14/07.
- Notice to Utilization Review Agent of Assignment of Independent Review Organization dated 11/14/07.
- Confirmation of Receipt of a Request for a Review by an Independent Review Organization dated 11/13/07.
- Request form Request for a Review by an Independent Review Organization dated 11/1/07.
- Authorization Request dated 10/2/07.
- Pre-Authorization Request dated 9/17/07.
- Requesting Appeal dated 10/9/07, 9/19/07.
- Communication dated 10/9/07, 9/19/07.
- Follow-Up Examination dated 9/17/07, 8/22/07.

NO GUIDELINES WERE PROVIDED BY THE URA FOR THIS REVIEW.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

**Age:** xx years

**Gender:** Female

**Date of Injury:** xx/xx/xx

**Mechanism of Injury:** Not provided for this review.

**Diagnosis:** Failed back surgery syndrome; lumbar radiculopathy; myofascial syndrome; sacroiliac joint dysfunction.

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

The patient is a xx-year-old female who sustained a work-related injury on xx/xx/xx. The mechanism of injury was not documented. Current diagnoses included:

1. Failed back surgery syndrome.
2. Lumbar radiculopathy.
3. Myofascial syndrome.
4. Sacroiliac joint dysfunction.

The claimant was complaining of progressive worsening of low back pain and right hip and leg pain. The patient rated the pain score on VAS of 6/10. The claimant recently underwent right shoulder arthroscopy for rotator cuff repair. Current medications management consists of OxyContin 20 mg t.i.d., Ambien 10 mg q.h.s., Celexa 20 mg b.i.d., and Zanaflex 4 mg q.h.s. Clinical examination revealed an antalgic gait with the use of a cane, lumbar facet joint tenderness; right greater than left, positive right sacroiliac joint tenderness, positive Fabere's maneuver on the right, and deep tendon reflexes lower extremities were equal and symmetrical bilaterally. The requesting provider stated that this claimant had a radiofrequency ablation (RFA) of the sacroiliac joint performed on May 4, 2006, with greater than 15 months of pain relief. The submitted documentation failed to demonstrate quality and quantity of pain relief

following the procedure. In addition, there was no documentation noting a decrease, if any, of medication following and during this time and most importantly, an increase in function clinically. Therefore, without the above criteria, it is opinion of this reviewer that the recent denial of radiofrequency ablation of the right sacroiliac joint be upheld. This patient has a failed lumbar back surgery syndrome diagnosis, which involved

multiple sources as an origin of chronic pain. It is the opinion of this reviewer that it is reasonable to consider reconfirming sacroiliac joint dysfunction as a possible contributor to claimant's pain by repeating diagnostic sacroiliac joint injections on 2 separate occasions with 2 different types of local anesthetics to confirm positive diagnostic responses.

**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
- 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

**X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

Official Disability Guidelines, Treatment Index, 5th Edition, 2006/2007, under hip: SI joint block.

- 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)**

**X OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME  
FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**

Practice guidelines, 1st Edition, 2004, spinal diagnostic and treatment  
procedures, ISIS edited by N. Bogduk, MD.

*Interventional Techniques in the Management of Chronic Spinal Pain: Evidence-  
based Practice Guidelines*, Pain Physician. 2005: 8:1-47 [ASIPP Guidelines].  
2007 – “Limited evidence and support radiofrequency neurotomies for SI joint  
pain.”