

True Decisions Inc.

An Independent Review Organization

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DATE OF REVIEW: July 6, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity for medial branch rhizotomy right S1 joint

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

Board Certified Orthopedic Surgeon

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

MRI lumbar spine, 12/23/07

New patient exam, Dr. 01/31/08

Procedure 04/11/08

F/U, Dr. 04/18/08

Peer review, Dr. 05/13/08

Peer review, Dr. 06/09/08

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female with a date of injury of xx/xx/xx. The injury occurred when the claimant tripped over a large dog and injured her back. An MRI of 12/23/07 revealed a slight straightening of the lordotic curvature which may have indicated a spinal muscle spasm; otherwise it was a normal MRI. The claimant had a right sacroiliac injection on 04/11/08 which gave eighty percent relief for a couple of days. The doctor diagnosed

her with low back pain due predominantly to sacroiliac joint dysfunction, the right greater than the left.

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

Based on a careful review of all medical records, the Reviewer would agree with the previous denials based on ODG guidelines. There is no indication for an SI joint radiofrequency ablation. There is mixed information in peer reviewed literature regarding the efficacy of this procedure. Studies were not reliable. Radiofrequency neurotomy is not recommended for SI joint dysfunction.

Official Disability Guidelines Treatment in Worker's Comp 2008 Updates, (web site) low back, [Facet joint radiofrequency neurotomy](#)

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
- 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)**