

# P-IRO Inc.

An Independent Review Organization  
835 E. Lamar Blvd., #394  
Arlington, TX 76011  
Fax: 866-328-3894

Notice of Independent Review Decision

**DATE OF REVIEW:** 03/25/2008

**IRO CASE #:**

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

Right SIJ L5, S1-S5 medial branch block RF rhizotomy under fluoroscopy.

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

M.D., Board Certified in pain management and anesthesiology under the American Board of Anesthesiologists.

**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  
Denial Letters 2/13/08 and 3/5/08  
Letter from 3/20/08  
2/20/08  
2/06 thru 12/07  
Ortho 1/12/06  
1/11/08

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient was injured while on the job on xx/xx/xx. Since that time, the patient has been suffering from "right hip, thigh and buttock tenderness." A request for a

repeat right SI joint medial branch radiofrequency rhizotomy at L5, S1-S5 was requested on an office visit note dated 01/11/08. On that date, it is difficult to tell where the patient's pain is located. Per the HPI, the patient only reported "some radiation to right ankle and foot." The Reviewer is assuming that the patient's pain starts from the back. In addition, on physical exam there are only two positive physical exam findings noted from the *Official Disability Guidelines* ("positive right Faber's and positive Gaenslen's"). There is also a chart review performed on 02/20/08 by Dr. that states "injections" are "not considered reasonable and necessary at this time."

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

Per the *Official Disability Guidelines*, SIJ radiofrequency rhizotomy is "not recommended." In addition, the diagnosis of SI joint-related pain is questionable in this patient given that the *Official Disability Guidelines* require "at least three positive exam findings" that are listed in the *Official Disability Guidelines*. Of the exam findings that are listed in the *Official Disability Guidelines*, only two are noted on the physical exam performed on 01/11/08. Also, there is some question as to whether or not anymore interventional procedures are indicated in this patient per the chart review performed by Dr. on 02/20/08. Therefore, given this information, a radiofrequency rhizotomy of the SI joint is not indicated at this time.

**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)