

I-Decisions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: 03/23/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

RFL of left lateral sacral nerve branch with fluoroscopy, followed by post-injection Physical Medicine x 1 session.

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)

Upon independent review the reviewer finds that the requested RFL of the left sacral nerve branch with fluoroscopy is not medically necessary. The reviewer also finds that one post-injection physical medicine session is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 2/12/08, 2/26/08

ODG Guidelines and Treatment Guidelines

Email, 3/4/08

Position Statement, 3/7/08
Solutions, MD, 1/17/08, 1/11/08, 2/20/08, 12/13/07, 12/6/07, 11/30/07, 11/29/07,
11/8/07
DC, 9/13/07
MRI of Lumbar Spine, 11/20/07
XRay of Lumbar Spine, 11/20/07
Diagnostics, Inc., MD, 10/8/07

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient was injured when she attempted to lift a “motor chair to put in a bin.” Since that time, this patient suffers from bilateral low back pain (left greater than right). Per the office visit note dated 12/13/07, a “left lumbar facet and left sacroiliac joint injection at five levels” was requested. On 01/17/08, it was stated that the patient “is having more than 75% relief of the left SI and left lumbar facet injection which she received on 01/11/08.” Because the patient received significant but temporary pain relief, a radiofrequency nerve ablation of the left SI joint was requested.

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

Per the *Official Disability Guidelines*, radiofrequency nerve ablation of the SI joint is “not recommended.” Therefore, this is not indicated. In addition, from a diagnostic standpoint, it is difficult to tell whether the patient is suffering from SI joint pain or facet joint pain given that both the SI joint and the facets joints were injected on the same day. Therefore, even if radiofrequency nerve ablation was accepted as a treatment, it would not be indicated in this case due to an inaccurate diagnostic test.

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)