



Professional Associates, P. O. Box 1238, Sanger, Texas 76266 Phone: 877-738-4391 Fax: 877-738-4395

Notice of Independent Review Decision

DATE OF REVIEW: 10/21/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient right radiofrequency ablation (RFA) at S1-S3

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

Board Certified in Orthopedic Surgery

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.

Outpatient right RFA at S1-S3 – Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Evaluations with M.D. dated 12/30/08, 01/27/09, 02/24/09, 03/25/09, 04/22/09, 05/19/09, 06/16/09, 07/14/09, 08/11/09, 09/11/09, 10/06/09, 11/03/09, 12/01/09, 01/05/10, 02/02/10, 03/02/10, 03/30/10, 04/27/10, 05/25/10, 06/22/10, 07/22/10, 08/17/10, and 09/14/10

A letter of adverse determination, according to the Official Disability Guidelines (ODG), from D.O. dated 09/15/10

Authorization request forms from Authorization Specialist at, dated 09/09/10 and 09/15/10

A letter of non-certification, according to the ODG, from M.D. dated 10/04/10

The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY [SUMMARY]:

On 01/27/09, Dr. increased Vicodin to 10/500 b.i.d. On 02/24/09 and 05/19/09, Dr. recommended a lumbar epidural steroid injection (ESI). On 08/11/09, Dr. increased Zanaflex to 4 mg. t.i.d. A right SI joint injection was recommended by Dr. on 10/06/09. On 01/05/10, Dr. stopped the Voltaren and prescribed Lidoderm. On 08/17/10, Dr. recommended a right S1-S3 RFA. On 09/09/10 and 09/15/10, Ms. wrote letters of authorization request. On 09/15/10, Dr. wrote letter of non-certification for a right RFA at S1-S3. On 10/04/10, Dr. also wrote a letter of non-certification for a right RFA at S1-S3.

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

There is no indication that the sacroiliac joint is the source of the patient's pain given the less than optimum results from the prior sacroiliac joint injection. Further, a review of the current Official Disability Guidelines (ODG) does not provide robust evidence to support the clinical benefit of a sacroiliac joint radiofrequency ablation. Third, there is no detailed physical examination. Fourth, there is no documentation of failure of conservative management. Therefore, in my opinion, the requested outpatient right RFA of S1 to S3 is neither reasonable nor necessary according to the ODG and the previous adverse determinations should be upheld.

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 KNOWLEDGBASE
- 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)**