



Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 11/10/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of bilateral SI joint radiofrequency thermocoagulation (64622, 64623, 77003, 99144 and 99145).

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

The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation. This reviewer has been practicing for greater than 10 years.

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)

The reviewer agrees with the previous adverse determination regarding prospective medical necessity of bilateral SI joint radiofrequency thermocoagulation (64622, 64623, 77003, 99144 and 99145).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:
Dr.

These records consist of the following (duplicate records are only listed from one source): Records reviewed from Dr.: 8/12/08/10 through 10/14/10 office notes by Dr. 6/28/10 operative report, 6/15/10 lumbar CT report, 5/5/10 DD report by MD, SIE DXI lumbar limited report of 5/11/09, 3/31/10 through 8/25/10 RADAR reports, MD office reports 8/5/10, Ph D reports 6/3/10, 5/28/10 report by DC, 10/21/09 PT progress notes, operative report 5/11/09, MD report 5/11/09, MD report 4/7/09, 10/8/08 operative report and CT of lumbar spine report 2/12/09.

: various DWC 73 reports, 9/29/10 denial letter and 10/14/10 denial letter.

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

Records indicate that this patient was injured on xx/xx/xx. He apparently developed lower back, right leg, hip, and groin pain. He saw a number of physicians for treatment and had extensive and aggressive treatment. An MRI study of the lumbar spine performed at some time that is not indicated in the medical record apparently showed multilevel lumbar spondylosis with right foraminal disk herniation at L4-5 and right central and subarticular herniation at L5-S1 with bilateral foraminal narrowing at L4-5 and L5-S1. Records indicate that the patient had physical therapy. He underwent facet injections on three occasions and apparently obtained no significant relief of symptoms. EMG and nerve conduction studies performed on June 10, 2008 were within normal limits. Lumbar epidural steroid injections performed in the fall of 2008 on three different occasions apparently did not relieve the symptoms.

On May 11, 2009, M.D. performed an L4 through S1 laminectomy and facetectomy, with spinal instrumentation and fusion at L4-5 and L5-S1. He was diagnosed with a post laminectomy syndrome and a chronic pain syndrome and has been treated by M.D. with multiple medications including Lortab, Lyrica, Ultram, and Zanaflex. He also received Tofranil to facilitate sleep.

A note from M.D. dated April 28, 2010 indicated that the patient was experiencing sacroiliac joint pain. A sacroiliac joint injection was recommended and on June 28, 2010, diagnostic and therapeutic sacroiliac joint blocks were performed with an anesthetic and steroids. According to the medical record, the injured worker had 100% relief of his sacroiliac joint pain lasting 24 hours.

On June 15, 2010, a CT scan of the lumbar spine showed a mature bony fusion across the posterior elements at L4-5 and L5-S1. Dr. noted on August 25, 2010 that the patient had received 100% relief of pain for 24 hours following his sacroiliac injections and recommended radiofrequency thermo coagulation of the sacroiliac joints. This case was reviewed by two physicians, M.D. and M.D. and both of those reviewing physicians felt that radiofrequency thermo coagulation was not medically necessary.

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

This individual was injured at work on xx/xx/xx. Initially, he was said to have lumbar spine dysfunction and he underwent aggressive treatment including facet joint injections, lumbar epidural steroid injections, physical therapy, multiple

medications, and ultimately a surgical procedure for spinal instrumentation and fusion at L4-5 and L5-S1. He continued to have back pain and was diagnosed with a post laminectomy syndrome and chronic pain. His examination was said to be consistent with sacroiliac joint dysfunction in April, 2010 and sacroiliac joint injections were performed on June 28, 2010. A local anesthetic and steroid were injected into the sacroiliac joints.

According to the medical record, the injured worker had 24 hours of 100% relief of symptoms following the injection. There is no further statement regarding the benefit of the injections in terms of longer lasting pain relief. ODG Guidelines indicate that a positive diagnostic sacroiliac joint block would be at least an 80% relief of pain for the duration of the local anesthetic. ODG Guidelines further state that if steroids are injected, there should be 70% pain relief lasting at least six weeks. The injured worker had 100% relief of his sacroiliac joint pain, according to this record, but there is no indication of whether the relief lasted longer than that or if there was any benefit from the injected steroid.

The ODG Guidelines categorically state that sacroiliac joint radiofrequency neurotomy is not recommended. The Guideline does reference small studies that indicate there is preliminary evidence that S1 to S3 lateral branch radiofrequency neurotomy may provide intermediate term relief in selected patients. Only 14% of the patients who underwent the radiofrequency neurotomy, however, had persisting pain relief at one year following the procedure. The Guidelines recognize that there is preliminary evidence that some selected patients may obtain relief, but they state that larger studies are needed to confirm the benefit of this procedure and to determine optimal candidates and treatment parameters. The ODG Guidelines do not recommend sacroiliac joint radiofrequency neurotomy and therefore, this procedure would not be considered medically necessary.

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)