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Notice of Independent Review Decision

DATE OF REVIEW: 5/16/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a left sacroiliac rhizotomy.

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 Orthopedic Surgery. The 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 the left sacroiliac rhizotomy

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient was injured on xx/xx/xx secondary to an on the job injury. On 3/28/11, the large body habitus claimant was documented to have persistent pain and tenderness at the left sacroiliac joint. However, he was noted to have had significant pain reduction from sacroiliac injections. He was prescribed narcotic analgesics, muscle relaxants, weight-loss and an evaluation for a left SI joint rhizotomy. On 12/16/10, the pelvic MRI was noted to be unremarkable. The 12/14/10 dated MRI revealed osteoarthritis of the hips and some lumbar disc bulges. On 11/30/10, reference was made to a diagnosis of radiculopathy and post-traumatic SI joint pain. Both a myelogram and MRI reportedly did not show nerve compression. On 8/3/10, the claimant had been noted to have originally fallen onto his buttocks and had failed treatment to the back itself.

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

The reviewer notes it is not fully evident that the left sacroiliac joint is the primary pain generator in this case. (The claimant does have documented osteoarthritis of the left in addition to lumbar spine pathology, each of which may be contributing to the left hip area pain.) In addition, objective physical findings evidencing SI joint dysfunction have not been evidenced, (as referenced below.) A reported positive response to injection does not fully support that the affected SI joint is the pain generator (also as referenced below.) Finally, the proposed procedure (especially with a lack of definitive establishment of the SI joint being a significant pain generator) is not supported by the applicable ODG criteria noted below.

Reference: ODG-Pelvis/Hip Sacroiliac Joint: Criteria for “blocks.”

Diagnosis: Specific tests for motion palpation and pain provocation have been described for SI joint dysfunction: Cranial Shear Test; Extension Test; Flamingo Test; Fortin Finger Test; Gaenslen’s Test; Gillet’s Test (One Legged-Stork Test); Patrick’s Test (FABER); Pelvic Compression Test; Pelvic Distraction Test; Pelvic Rock Test; Resisted Abduction Test (REAB); Sacroiliac Shear Test; Standing Flexion Test; Seated Flexion Test; Thigh Thrust Test (POSH). Imaging studies are not helpful. It has been questioned as to whether SI joint blocks are the “diagnostic gold standard.” The block is felt to show low sensitivity, and discordance has been noted between two consecutive blocks (questioning validity). There is also concern that pain relief from diagnostic blocks may be confounded by infiltration of extra-articular ligaments, adjacent muscles, or sheaths of the nerve roots themselves. Sacral lateral branch injections have demonstrated a lack of diagnostic power and area not endorsed for this purpose.

According to the ODG it is not recommended. Multiple techniques are currently described: (1) a bipolar system using radiofrequency probes (Ferrante, 2001); (2) sensory stimulation-guided sacral lateral branch radiofrequency neurotomy (Yin, W 2003); (3) lateral branch blocks (nerve blocks of the L4-5 primary dorsal rami and S1-S3 lateral branches) (Cohen, 2005); & (4) pulsed radiofrequency denervation (PRFD) of the medial branch of L4, the posterior rami of L5 and lateral branches of S1 and S2. (Vallejo, 2006) This latter study applied the technique to patients with confirmatory block diagnosis of SI joint pain that did not have long-term relief from these diagnostic injections (22 patients). There was no explanation of why pulsed radiofrequency denervation was successful when other conservative treatment was not. A > 50%

reduction in VAS score was found for 16 of these patients with a mean duration of relief of 20 ± 5.7 weeks. The use of all of these techniques has been questioned, in part, due to the fact that the innervation of the SI joint remains unclear. There is also controversy over the correct technique for radiofrequency denervation. A recent review of this intervention in a journal sponsored by the American Society of Interventional Pain Physicians found that the evidence was limited for this procedure. (Hansen, 2007) See also Intra-articular steroid hip injection; & Sacroiliac joint blocks.

Recent research: A small RCT concluded that there was preliminary evidence that S1-S3 lateral branch radiofrequency denervation may provide intermediate-term pain relief and functional benefit in selected patients with suspected sacroiliac joint pain. One, 3, and 6 months after the procedure, 11 (79%), 9 (64%), and 8 (57%) radiofrequency-treated patients experienced pain relief of 50% or greater and significant functional improvement. In contrast, only 2 patients (14%) in the placebo group experienced significant improvement at their 1-month follow-up, and none experienced benefit 3 months after the procedure. However, one year after treatment, only 2 patients (14%) in the treatment group continued to demonstrate persistent pain relief. Larger studies are needed to confirm these results and to determine the optimal candidates and treatment parameters for this poorly understood disorder.

The reviewer has found this procedure to not be medically necessary at this time. This finding is based upon the ODG, his medical opinion and the records provided for review.

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)