

Notice of Independent Review Decision

REVIEWER'S REPORT

Date notice sent to all parties: August 20, 2012

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Radiofrequency lesioning, right SI joint L5, Rs1, Rs2, Rs3.

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

M.D., licensed in the State of Texas, board certified in the specialty of Physical Medicine and Rehabilitation, in active practice for greater than 40 years

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

- | | |
|---|---|
| <input checked="" type="checkbox"/> Upheld | (Agree) |
| <input type="checkbox"/> Overturned | (Disagree) |
| <input type="checkbox"/> Partially Overturned | (Agree in part/Disagree in part) |

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
847.0	64635		Prosp.		06/07/12				Upheld
847.0	64635		Prosp.		07/13/12				Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

1. Certification of independence of the reviewer.
2. TDI case assignment.
3. Letters of denial 06/07/12 & 07/13/12, including criteria used in the denial.
4. Treating doctor's evaluation and follow up 01/12/12 – 07/10/12. Information prior to 2012 available upon request.
5. Rehab re-evaluation 01/25/12.
6. Laboratory report 02/24/12.
7. Operative report 05/18/12.
8. Radiology report MRI L-spine w/o contrast 03/05/12.

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a man who reported injury on xx/xx/xx. He underwent an MRI scan of the lumbar spine on 03/05/12 with noted 1-mm bulge at L4/L5. The patient has undergone two (2) right sacroiliac joint injections with decrease or reduction completely of prescription medication and improved functional activity. However, the effectiveness of these injections did not have lasting value, and because of that, the patient's treating doctor, Dr., has requested a radiofrequency neurotomy for what she indicates would be a "permanent" fix as the patient has had excellent relief with the

injections. The patient has been noted to have lumbar spine range of motion of 35 degrees flexion and 20 degrees extension and is also noted to have a right Patrick Fabere test with tenderness noted over the right sacroiliac joint. Straight leg raising was negative bilaterally. The patient was found to have a positive right compression test and right Fortin finger test, as well. No trigger points were noted upon palpation. Muscle strength was rated as 5/5.

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

Review of the original denial and reconsideration denial note that the radiofrequency ablation for sacroiliac joint disorders is not recommended in the Official Disability Guidelines criteria. Denial in both cases was based on failure to meet ODG criteria. The primary rationale of the ODG criteria is that there is an insufficient number of quality controlled studies to support any long term benefit from this treatment approach. There is no controverting information provided by the treating doctor that would overcome the ODG criteria.

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 (1), three (3), and six (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 two patient (14%) in the placebo group experienced significant improvement at their one-month follow up; and, none experienced benefit three months after the procedure. However, one year after treatment, only two (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 (Cohen, 2008).

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 (Below).**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (Below).**
Cohen, 2008