



Notice of Independent Review Decision

REVIEWER'S REPORT

Date notice sent to all parties: September 10, 2012

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient left sacroiliac rhizotomy.

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

M.D., Board Certified in orthopedic surgery

REVIEW OUTCOME:

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

- Upheld (Agree)
- Overtumed** (Disagree)
- Partially Overtumed (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 Overtum</i>
724.4			Prosp.						Overtum

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

1. Certification of independence of the reviewer.
2. TDI case assignment.
3. Letters of denial 07/24/12 & 08/16/12, including criteria used in the denial.
4. Operative reports 04/05/11, 08/31/11, and 02/15/12.
5. Treating doctor's evaluations and follow up 0315/11 – 07/09/12.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male with sacroiliac disease in pseudo-radicular symptoms. He has been treated successfully in the past with over six months of relief after selective facet blocks and radiofrequency ablation to the left L2 through L5 levels. Sacroiliac rhizotomy has been requestd and denied due to the lack of medical necessity and scientific literature to support the procedure.

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

Based on the patient's favorable response to both the trial or radiofrequency ablation, as well as SI joint blocks, dorsal rhizotomy appears to be within ODG guidelines and medically reasonable and necessary. The patient has failed conservative care and this procedure would be favorable to surgical management.

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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)