



Notice of Independent Review

**REVIEWER'S REPORT**

**DATE NOTICE SENT TO ALL PARTIES:** 07/25

**IRO CASE #:**

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

Texas-licensed M.D., board certified in Anesthesiology, added qualifications in Pain Medicine

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Outpatient sacroiliac joint RFTC; left L5, S1, S2, S3 (64622, 64635)

**REVIEW OUTCOME:**

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

- Upheld** (Agree)
- Overtured** (Disagree)
- Partially Overtured** (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 Overtured</i>
721.3	64622		Prosp.				Xx/xx/xx		Upheld
721.3	64635		Prosp.				Xx/xx/xx		Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

1. TDI case assignment.
2. Letter of denial 07/02/13 & 06/10/13, including criteria used in the denial.
3. Operative reports 03/15/13, 12/14/12, 10/28 & 01/07/10.
4. MRI report 10/18/12.
5. Treating doctor's office visit notes 02/02/13 – 07/11/13.

**PATIENT CLINICAL HISTORY (SUMMARY):**

The claimant sustained a back injury on xx/xx/xx moving furniture. Multiple modalities have been utilized, including medications and injections. There has been a left L5-S1 lumbar laminectomy. The EMG shows a left L5 radiculopathy. The MRI shows a herniated disc at L4-L5. Epidural steroid injections have been performed with minimal relief. A left sacroiliac joint injection was performed and there was relief for the duration of the local anesthetic.

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

Even though it is standard clinical practice to perform radiofrequency ablation of the sacroiliac joint, this review is based on the ODG. The Official Disability Guidelines do not recommend radiofrequency sacroiliac joint ablation since there is controversy over the correct technique and there is limited evidence to support this procedure.

**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
- AHCPH-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 judgment, clinical experience and expertise in accordance with accepted medical Standards
- Mercy Center Consensus Conference Guidelines
- Milliman Care Guidelines
- ODG-Office 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

**INDEPENDENT REVIEW INCORPORATED**

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- \_\_\_\_\_ Peer-reviewed, nationally accepted medical literature (Provide a Description):
- \_\_\_\_\_ Other evidence-based, scientifically valid, outcome-focused guidelines (Provide a Description)