

MAXIMUS Federal Services, Inc.
4000 IH 35 South, (8th Floor) 850Q
Austin, TX 78704
Tel: 512-800-3515 ♦ Fax: 1-877-380-6702

Notice of Independent Review Decision

DATE OF REVIEW: February 13, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Rhizotomy of the right sacroiliac joint (64636).

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

M.D., Board Certified in Physical Medicine and Rehabilitation and Pain Medicine.

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 requested rhizotomy of the right sacroiliac joint (64636) is not medically necessary.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who reported a work-related injury on xx/xx/xx. The patient indicated she was dragged when the vehicle brakes gave out and the car began rolling. According to the documentation submitted for review, the patient has a diagnosis of solitary sacroiliitis. On 5/14/13, the patient was diagnosed with lumbar disc disorder, lumbar radiculitis, and sacroiliac sprain/strain. At that time, it was noted that the patient was pending surgery to the lower back. On 12/3/14 the patient presented for a follow-up visit regarding right sacroiliac joint pain. A rhizotomy of the right sacroiliac joint was recommended. The patient was utilizing hydrocodone/acetaminophen 10/325 mg on an as needed basis. Upon physical examination, there was midline spinal tenderness and paralumbar tenderness. The patient was informed of the risks and benefits of the sacroiliac joint rhizotomy.

The URA indicated that the patient did not meet Official Disability Guidelines (ODG) criteria for the requested services. Per the denial letter dated 1/9/15 the URA indicates that there is no current clinical documentation of provocative tests or functional limitations. The URA further indicates that ODG guidelines do not recommend SI joint radiofrequency neurotomies.

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

According to the Official Disability Guidelines (ODG), a sacroiliac (SI) joint radiofrequency neurotomy is not recommended. The use of all 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. Larger studies are needed to confirm results and determine the optimal candidates and treatment parameters. According to the documentation provided, the patient was diagnosed with solitary sacroiliitis. However, there was no documentation of at least three positive provocative examination findings suggestive of sacroiliac joint pathology. The patient's physical examination on 12/3/14 only revealed tenderness to palpation. There was no documentation of a significant functional or musculoskeletal deficit. Based on the clinical documentation provided and the Official Disability Guidelines, the rhizotomy of the right sacroiliac joint (64636) is not medically necessary. In accordance with the above, I have determined that the requested rhizotomy of the right sacroiliac joint is not medically necessary for treatment of the patient's medical condition.

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 JUDGMENT, 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)