



PROFESSIONAL ASSOCIATES

Notice of Independent Review Decision

DATE OF REVIEW: 04/23/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Bilateral SI joint rhizotomy

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

Board Certified in Orthopedic Surgery

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Bilateral SI joint rhizotomy - Upheld

PATIENT CLINICAL HISTORY

A lumbar CT scan interpreted by Dr. on 05/31/05 revealed spondylolisthesis at L5-S1, postoperative changes at L4-L5 and L5-S1, and central canal narrowing with a disc bulge at L3-L4. On 11/22/06, Dr. performed bilateral SI joint injections. Chiropractic therapy was performed with Dr. from 01/16/07 through 10/22/07 for a total of five sessions. On 01/30/07, Dr. performed bilateral SI joint injections. On 10/22/07, Dr. recommended an SI rhizotomy and continued Norco

and Ambien. On 02/25/08, Ms. also recommended a bilateral SI joint rhizotomy. On 03/03/08 and 03/19/08, wrote letters of non-certification for the rhizotomy. On 03/03/08, Dr. wrote a letter of non-certification for the rhizotomy. On 03/17/08, Dr. wrote a letter of non-certification for the rhizotomy. Chiropractic therapy was performed with Dr. on 03/20/08, 03/25/08, and 04/01/08.

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

The patient has failed spinal surgery syndrome. He underwent a 360 degree fusion at L4-L5 and L5-S1. There were multiple causes for his pain, including failure of the fusion and the pedicle screws breaching the lateral aspect of the spinal canal and irritating the nerves. In addition, there were degenerative changes at L3-L4. He had inconsistent and short term relief from previous sacroiliac joint injections. This does not prove that the sacroiliac joint is the source of pain. The ODG does not approve of the use of sacroiliac rhizotomy as a treatment for sacroiliac pain. For the reasons listed above, the unclear diagnosis, and the lack of direction from the ODG, in my opinion, the requested bilateral sacroiliac joint rhizotomy is neither reasonable nor necessary.

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 AND KNOWLEDGE BASE
- 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)