

P-IRO Inc.

An Independent Review Organization
835 E. Lamar Blvd., #394
Arlington, TX 76011
Phone: 817-274-0868
Fax: 866-328-3894

DATE OF REVIEW: April 21, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medial branch rhizotomy right L5-S1 and S3

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

Board Certified Orthopedic Surgeon

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines
Office notes, Dr. 08/09/04, 08/09/06, 09/24/07, 11/05/07, 02/25/08
Bone scan, 09/07/06
EMG/NCV, 09/06/07
Office note, Physician Assistant, 09/10/07
MRI, 09/10/07
SI injections, 10/30/07, 02/13/08
Repeat SI injection, Dr. 01/21/08
Denial, 03/12/08, 03/26/08
Appeal, 03/17/08

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female injured in an unknown manner. She had an L5-S1 interbody fusion with cages noted on a 08/09/04 note from Dr. At that time the claimant was doing well.

On 08/09/06 Dr. saw the claimant noting that she has developed back pain after stacking milk cartons. Her motion was limited and the right SI joint was described as exquisitely tender. She had a "dramatic" FABER 4. Testing was recommended. The bone scan in 09/06 showed surgical changes only.

The 09/06/07 EMG/NCV was read as normal. On the 09/10/07 with the PA-C it was noted that the claimant not been seen since 2006. She reported leg pain more than back pain. The examination was unremarkable other than right SI tenderness.

A 09/10/07 MRI of the lumbar spine showed an L3-4 posterior protrusion slightly to the right of midlines without stenosis. There was L4-5 fusion graft with no central or neural foraminal stenosis. At L5-S1 there was fusion graft with minimal narrowing of the right foramen. On return to Dr. on 09/24/07 she had pain with light touch and a positive FABER 4. The physician felt that the claimant's weight was contributing to her pain. He recommended a right SI injection. This was done on 10/30/07 with a pain reduction from 9/10 to 0/10. A second injection was given on 02/13/08 with no relief in the anesthetic period but 24 hours relief from the steroid.

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

This is a female who reportedly suffered an injury to her back. The description of her injury is not provided within the records. She has been diagnosed with an L5-S1 transitional syndrome and SI joint dysfunction after lumbar fusion.

Within the clinical records there are documents that report that she has had ongoing back pain since surgery in 2002. She had a bone scan from 2006, which described degenerative changes and EMG's from 2007, which were described as normal. More recently, in October 2007, she underwent an SI joint injection, which reportedly relieved her symptoms. Subsequently, she went through a repeat injection, but saw virtually no relief with the anesthesia portion and reportedly experienced 24 hours of relief with the steroid.

ODG guidelines do not specifically discuss radiofrequency neurotomy in the SI joint; although, they do discuss the indications for individuals who have undergone facet injections. In that particular case, the expectations are that individuals should have seen meaningful improvement following facet blocks in general on more than one occasion. What is of concern in Ms.'s case is the fact that although the SI joint injection reportedly offered her relief, the second injection offered her virtually no relief including no relief with the local anesthetic part, and what would be uncharacteristic relief related to the "steroid effect".

In the absence of well-controlled literature to support its use in the SI joint, it would be difficult to recommend this particular treatment at this stage as either being reasonable or medically necessary. Furthermore, the clinical information is not totally convincing, particularly in absence of response to the Xylocaine injection, after injection #2 that this individual truly suffers from SI joint pathology. As such, the request for radiofrequency rhizotomy of the SI joint cannot be recommended as either reasonable or medically necessary.

Official Disability Guidelines Treatment in Worker's Comp 2008, Low Back
Under study. Conflicting evidence is available as to the efficacy of this procedure and approval of treatment should be made on a case-by-case basis. Studies have not demonstrated improved function. Also called Facet rhizotomy, Radiofrequency medial branch neurotomy, or Radiofrequency ablation (RFA),

Criteria for use of facet joint radiofrequency neurotomy:

(1) Treatment requires a diagnosis of facet joint pain using a medial branch block as described above. See [Facet joint diagnostic blocks](#) (injections).

(2) While repeat neurotomies may be required, they should not occur at an interval of less than 6 months from the first procedure. A neurotomy should not be repeated unless duration of relief from the first procedure is documented for at least 12 weeks at $\geq 50\%$ relief. The current literature does not support that the procedure is successful without sustained pain relief (generally of at least 6 months duration). No more than 3 procedures should be performed in a year's period.

(3) Approval of repeat neurotomies depends on variables such as evidence of adequate diagnostic blocks, documented improvement in VAS score, and documented improvement in function.

(4) No more than two joint levels are to be performed at one time

(5) If different regions require neural blockade, these should be performed at intervals of no sooner than one week, and preferably 2 weeks for most blocks.

(6) There should be evidence of a formal plan of additional evidence-based conservative care in addition to facet joint therapy.

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)