

**SOUTHWEST MEDICAL EXAMINATION SERVICES, INC.**  
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Notice of Independent Review Decision

**DATE OF REVIEW:** July 21, 2008

**IRO CASE #:**

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

Left S1 rhizotomy to include CPT code 64622

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

Board Certified Orthopaedic 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**

Medical records from the URA include:

- Official Disability Guidelines, 2008

- Request for Review by an Independent Review Organization, 07/08/08
- , 12/04/06
- , 12/28/06, 12/04/07, 05/08/07, 06/19/07, 07/12/07, 07/19/07, 08/23/07, 09/20/07, 12/04/07, 12/12/07, 12/13/07, 12/17/07, 12/27/07, 01/02/08, 02/26/08, 02/27/08, 04/01/08, 04/03/08, 05/15/08, 05/27/08
- for Diagnostics and Surgery, 01/10/07, 01/16/07, 07/11/07, 08/28/07
- , 06/25/08, 07/07/08
- , M.D., 05/01/07, 06/14/07, 02/15/08

Medical records from the Requestor/Provider include:

- Texas Department of Insurance, , 07/10/08
- Request for Review by an Independent Review Organization, 07/08/08
- , 12/04/06
- , 12/27/06, 12/28/06, 01/10/07, 05/08/07, 06/19/07, 07/12/07, 07/19/07, 08/23/07, 09/20/07, 11/01/07, 12/13/07, 12/17/07, 12/27/07, 01/02/08, 02/26/08, 02/27/08, 04/01/08, 04/03/08, 05/15/08, 05/27/08
- For Diagnostic and Surgery, 01/16/07, 05/01/07, 08/28/07
- , M.D., 06/14/07, 02/15/08
- , M.D., 07/11/07

### **PATIENT CLINICAL HISTORY:**

The patient sustained a low back injury while lifting, producing apparent low back pain that radiated to the left leg. The date of the injury is xx/xx/xx

An MRI of the lumbar spine performed on December 4, 2006 revealed no evidence for significant disc herniation, central spinal, or neuroforaminal stenosis. There was mild facet hypertrophy at L4-5 and L5-S1.

The patient underwent physical therapy, left sacroiliac joint injections, left piriformis injections, left L4-5 and L5-S1 facet injections with no lasting improvement. A left sacroiliac joint rhizotomy has been recommended.

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

After a review of the provided records, it is my opinion that the patient's chronic pain problem can very well be cataloged as nonspecific low back pain. The attempts to isolate or pinpoint the diagnosis have been several and the diagnoses have varied from early on. Even when she had facet injections and ablation, the response was less than satisfactory

and she continued to have a chronic pain problem. In all medical probability, she will not have any lasting relief from the proposed treatment. The treatment itself is somewhat controversial as it has been around for a long time and until now there is no clear, absolute convincing evidence that it provides definite and lasting relief. This opinion is based on years of practice dealing with chronic low back pain patients, as well as the literature which is amply documented on the ODG Guidelines online. Therefore, in my opinion, the denial for the left S1 rhizotomy is upheld.

**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)**