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Notice of Independent Review Decision-Amended

Amended: March 26, 2009

DATE OF REVIEW: March 25, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Left sacroiliac joint rhizotomy

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
The physician providing this review is a Doctor of Medicine (M.D.). The reviewer is national board certified in Physical Medicine and Rehabilitation as well as Pain Medicine. The reviewer is a member of International Spinal Intervention Society and American Medical Association. The reviewer has been in active practice for ten years.

REVIEW OUTCOME

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

☒ Upheld (Agree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Texas Department of Insurance:

- Office visits (01/29/07 – 12/11/08)
- Diagnostics (01/24/07 – 03/29/07)
- Utilization review denials (01/20/09, 01/27/09)
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- Diagnostics (01/24/07 – 03/29/07)
- Office visits (01/29/07 - 01/09/09)
- Procedures (03/14/08 - 10/24/08)
- Procedures (03/14/08 - 10/24/08)

ODG Criteria has been used for denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

On xx/xx/xx, the patient was working on computers, bent over at 45 degrees angle to move computers up to some 50 to 60 pounds when he heard a snap in his back.

2007: On xx/xx/xx, the patient was evaluated at. X-rays of the lumbar spine revealed previous lumbar surgery with metallic cages at L5-S1. He was prescribed hydrocodone and Flexeril at emergency room (ER). D.C., saw the patient for pain in the lower back radiating in the right hip and buttock as well as the right leg to approximately the knee level. History was significant for fusion at L5-S1 in 1995. Examination revealed tenderness from L4 through S1 and the right sacroiliac (SI) joint; muscle spasms in the lumbar spine; positive FABERE, Gillet's, and Gaenslen's, straight leg raising (SLR) tests on the right; and facet loading at L4-L5 and L5-S1. Dr. assessed lumbar sprain/strain associated with fusion at L5-S1, right SI joint pain, facet inflammation at L4-L5 and L5-S1 on the right, and internal disc derangement at L4-L5. He prescribed Norco in conjunction with over-the-counter anti-inflammatories and treated the patient with electrical muscle stimulation (EMS) in conjunction with cryotherapy and manipulative procedures. D.O., prescribed Flexeril and refilled hydrocodone.

Magnetic resonance imaging (MRI) of the lumbar spine revealed: (1) Probable atypical hemangioma at the L2 vertebral body. (2) Mild right lateral recess narrowing from a small disc protrusion at L3-L4 impinging on the L4 nerve root. (3) Moderate foraminal narrowing at L4-L5 with a superimposed 0.5 cm foraminal protrusion on the left, narrowing the lateral recess with impingement of the left L5 nerve root. Computerized tomography (CT) of the lumbar spine revealed focus of abnormal signal intensity noted on the MRI corresponding to a region of poorly defined bony sclerosis could not be confirmed to be a hemangioma. This might be related to reactive changes related to the small adjacent Schmorl's node. A whole body bone scan was unremarkable.

In December, Dr assessed lumbalgia associated with facet inflammation from L4-S1 and SI joint inflammation and continued the patient on chiropractic therapy.

2008: In January, Dr. noted flare-up of the patient's condition. There was tenderness from L4 through S1 and bilateral SI joints. He prescribed Biofreeze pain gel, continued to treat him with chiropractic manipulations to the lumbosacral spine and bilateral SI joints, and recommended medial branch blocks.

Dr. noted sacral tilt with the right iliac crest being lower than the left and tenderness over the right SI joint. He assessed chronic intractable low back pain secondary to work injury with disc disease and new onset of SI joint dysfunction and treated the patient with Norco and Medrol Dosepak.

In March, M.D., performed bilateral L3, L4, and L5 medial branch blocks (MBB) with 50% relief during the first 72 hours. As a result of the previous surgery and failed MBB, the patient was referred to M.D., who assessed posterior bulging at L3-L4 and L4-L5, continued him on chiropractic therapy, recommended Med-X program for core stabilization and antiinflammatories.

From May through September, the patient was treated with chiropractic therapy and Med-X PT by Dr. and medications including Norco and Flexeril by Dr.

On October 24, 2008, Dr. performed left SI joint injection with corticosteroid with approximately 90%-95% relief in the symptoms. Post injection, Dr. ordered a confirmatory injection to the left SI joint. Dr. agreed for confirmatory injection.

2009: On January 9, 2009, Dr. noted pain in the low back on the left with radiation into the left leg and foot. The patient had undergone a second left SI joint block on December 26, 2008, which provided 80%-85% relief for the first week, but unfortunately the pain had slowly started to return. Examination revealed tenderness over the L4-S1 and left SI joint and positive FABERE test on the left. Dr. assessed lumbalgia associated with left SI inflammation and internal disc derangement above the fusion. He opined the diagnostic injection had provided 90% relief and the confirmatory injection with 85% relief with the pain returning, and as a result of this, the patient met the criteria for rhizotomy into the SI joint.

On January 20, 2009, the request for the left SI joint rhizotomy was denied with the following rationale: "*Medical necessity of the request for a left SI joint rhizotomy is not supported. ODG guidelines do not recommend SI joint radiofrequency neurotomy. ACOEM guidelines indicate: Radiofrequency neurotomy, neurotomy, and facet rhizotomy are not recommended for treatment of any spinal condition."*

On January 27, 2009, D.C., denied the appeal for left SI joint rhizotomy with the following rationale: "*It is clear that there is some quantitative relief of the claimant's symptomatology with the implementation of SI joint injections. However, the innervation of the region is unclear and the technique that was proposed is unclear. The failure to communicate and discuss the case with the provider warrants a denial of the proposed course of care based upon an inability to discern a clear best practice or technique. The application was not medically necessary and appropriate."*

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

Although a successful diagnostic SIJ block can confirm the presence of benign sacroiliac joint disorder in that region, there is no valid explanation provided in this record about how the proposed treatment would denervate the anterior innervation of the joint, thus leading to an effective treatment for the disorder.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

Not recommended. Multiple techniques are currently described: (1) a bipolar system using radiofrequency probes (Ferrante, 2001); (2) sensory stimulation-guided sacral lateral branch radiofrequency neurotomy (Yin, W 2003); (3) lateral branch blocks (nerve blocks of the L4-5 primary dorsal rami and S1-S3 lateral

branches) (Cohen, 2005); & (4) pulsed radiofrequency denervation (PRFD) of the medial branch of L4, the posterior rami of L5 and lateral branches of S1 and S2. (Vallejo, 2006) This latter study applied the technique to patients with confirmatory block diagnosis of SI joint pain that did not have long-term relief from these diagnostic injections (22 patients). There was no explanation of why pulsed radiofrequency denervation was successful when other conservative treatment was not. A > 50% reduction in VAS score was found for 16 of these patients with a mean duration of relief of 20 ± 5.7 weeks. The use of all of these 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. A recent review of this intervention in a journal sponsored by the American Society of Interventional Pain Physicians found that the evidence was limited for this procedure. (Hansen, 2007) See also Intra-articular steroid hip injection; & Sacroiliac joint blocks.

The SIJ receives innervation anteriorly as well.