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IRO Certificate #

Notice of Independent Review Decision

DATE OF REVIEW: 11/18/10

IRO CASE #:

Description of the Service or Services In Dispute
L5-S3 Rhizotomy

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

Physician Board Certified in Neurological Surgery

REVIEW OUTCOME

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

Upheld	(Agree)
<input checked="" type="checkbox"/> Overturned	(Disagree)
Partially Overturned	(Agree in part/Disagree in part)

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

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse determination letters, 11/2/10, 10/19/10
Institute notes and imaging report, 9/09 – 10/10
Operative report 9/1/10
Carrier Guidelines/ Research article
ODG guidelines

PATIENT CLINICAL HISTORY (SUMMARY):

The patient is a female who in was lifting in a twisted position, and developed low back pain. Medication, physical therapy and rest were not significantly helpful. On examination, straight leg raising is negative, and there is no evidence of radiculopathy on reflex, sensory or motor examination. The patient's examination is compatible with left-sided sacroiliac joint pathology as a source of her pain. Sacroiliac injections in April and August 2010 gave three months relief after the first injection, and only relief of two weeks after the second injection.

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

I disagree with the denial of the requested procedure. The patient remains with significant pain that is in all medical probability related to the sacroiliac joint, which showed good results with injections directly into that region. It is suggested that an MRI might be helpful, but it is doubtful that it would alter the recommendation of rhizotomy, as there is nothing on examination to suggest changes in the lumbar spine as the source of the patient's trouble. The proposed procedure has been documented to be successful by a very reputable institution.

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)