

SENT VIA EMAIL OR FAX ON  
Jun/29/2012

## P-IRO Inc.

An Independent Review Organization  
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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Jun/29/2012

**IRO CASE #:**

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

OP Right SI Rhizotomy

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

Orthopedic spine surgeon, practicing neurosurgeon

**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 medical necessity exists for each health care service in dispute.**

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

ODG - Official Disability Guidelines & Treatment Guidelines

12/13/10 – LUMBAR MYELOGRAM

12/13/10 – POST-MYELOGRAM CT LUMBAR SPINE

01/12/11 – OPERATIVE REPORT

02/07/11 – CLINICAL NOTE –MD

02/08/11 – CLINICAL NOTE –DO

02/08/11 – LABORATORY REPORT

04/25/11 – MEDICAL RECORD REVIEW –MD

05/06/11 – CLINICAL NOTE –DO

05/19/11 – CLINICAL NOTE –PA-C

05/23/11 – PHYSICAL THERAPY NOTE

05/25/11 – PHYSICAL THERAPY NOTE

05/26/11 – PHYSICAL THERAPY NOTE

05/26/11 – BEHAVIORAL HEALTH EVALUATION

06/21/11 – PHYSICAL THERAPY NOTE

06/23/11 – PHYSICAL THERAPY NOTE

08/09/11 – CLINICAL NOTE – PA-C

10/31/11 – CLINICAL NOTE –PA-C

11/08/11 – CLINICAL NOTE –DO

11/14/11 – CLINICAL NOTE –MD

01/23/12 – CLINICAL NOTE –PA-C

04/16/12 – CLINICAL NOTE – MD

05/14/12 – CLINICAL NOTE –MD

05/04/12 – UTILIZATION REVIEW DETERMINATION

05/22/12 – UTILIZATION REVIEW DETERMINATION

06/18/12 – REQUEST FOR REVIEW BY INDEPENDENT REVIEW ORGANIZATION

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a female with a history of lumbosacral pain with radiation down the extremities. Post-myelogram CT of the lumbar spine performed 12/13/10 revealed 360-degree lumbar fusion from L4 through S1 with hardware. There was no central spinal stenosis or foraminal stenosis. There was central spinal stenosis at L3-4 secondary to ligamentum flavum hypertrophy, degenerative facet hypertrophy, and bulge of the posterior disc margin. There was mild to moderate bilateral lateral recess narrowing. There was a stimulator device in the subcutaneous right buttock soft tissue with subcutaneous wires extending into the spinal canal at the T12 level lying dorsal to the thecal sac. The claimant underwent L3-4 interlaminar epidural steroid injection on 01/12/11. The claimant completed 5 sessions of physical therapy from 05/19/11 through 06/23/11.

The claimant saw Dr. on 10/31/11 with complaints of lumbosacral pain that extended to the bilateral lower extremities. Physical exam revealed the claimant favored her right lower extremity when transitioning from sitting to standing. There was significantly decreased range of motion of the lumbar spine. There was tenderness to palpation of the bilateral sacroiliac joints, right greater than left. Motor and sensory functions were intact. Straight leg raise was negative bilaterally. The claimant ambulated with an antalgic gait favoring the right lower extremity. The claimant was assessed with bilateral sacroiliac joint dysfunction and failed back surgery syndrome. The claimant was recommended for diagnostic sacroiliac joint injection. The claimant was seen for follow up on 01/23/12 with complaints of lumbosacral pain with radiation to the right lower extremity. Physical exam revealed decreased range of motion of the low back. There was point tenderness over the right sacroiliac joint. Faber was positive over the right sacroiliac joint. Straight leg raise was reported to be positive on the right. The claimant was assessed with worsening right sacroiliac joint dysfunction. The claimant was recommended for right sacroiliac joint injection.

The claimant was seen for evaluation on 04/16/12 with complaints of bilateral sacroiliac joint pain. The claimant reported 70% pain relief for several weeks following the sacroiliac joint injection. The claimant's medications included Norco Neurontin. Physical exam revealed positive Faber bilaterally, right greater than left. Pelvis compression test was positive. There was exquisite tenderness to palpation over the bilateral sacroiliac joints, left greater than right. Motor and sensory functions were intact. Straight leg raise was negative. The claimant was assessed with bilateral sacroiliac joint dysfunction. The claimant was recommended for right sacroiliac joint rhizotomy. The request for right sacroiliac joint rhizotomy was denied by utilization review on 05/04/12 as sacroiliac rhizotomy was not recommended by current evidence based guidelines. The request for right sacroiliac joint rhizotomy was denied by utilization review on 05/22/11 as sacroiliac rhizotomy was not recommended by current evidence based guidelines. Additionally, there was limited documentation to substantiate failure of conservative care. There were no recent physical therapy progress notes.

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

Based on the clinical documentation provided for review and current evidence based guidelines for the requested procedure, medical necessity is not established. The claimant has undergone prior injections and physical therapy with some improvement. The requested sacroiliac joint rhizotomy is not supported or recommended by current evidence based guidelines. The clinical literature available on the procedure does not establish its long-term efficacy as compared to other alternative procedures. Guidelines indicate that the procedure requires additional large randomized trials to establish the efficacy of the procedure. As the requested procedure is considered experimental and investigational by guidelines, the medical need for the requested service is not established and the prior denials are upheld.

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

ACOEM-AMERICA 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)