

Independent Resolutions Inc.

An Independent Review Organization
835 E. Lamar Blvd. #394
Arlington, TX 76011
Phone: (817) 349-6420
Fax: (817) 549-0311
Email: rm@independentresolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Jun/24/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Rhizotomy at L4-S3 X 3

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

PM&R and Pain Medicine

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:

ODG - Official Disability Guidelines & Treatment Guidelines

Clinical records 05/04/11-04/08/13

Behavioral medicine evaluation 06/19/12

Electrodiagnostic studies 04/14/10

CT myelogram lumbar spine 04/20/10

MRI lumbar spine 11/29/11

Procedure report 09/19/11

Prior utilization reviews 11/16/11-06/06/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who sustained an injury on xx/xx/xx. The patient was status post lumbar interbody fusion from L3 to S1. Prior hardware loosening was noted on CT myelogram studies. The patient underwent previous medial branch blocks bilaterally at L3-4 in 09/11. The patient continued to be seen for pain management and utilized MS Contin and morphine immediate release through 2012. The patient had a psychological evaluation regarding a spinal cord stimulator implant. A right sacroiliac joint injection was performed on 02/04/13 which provided approximately 40% relief of her symptoms on the following day. Clinical record on 03/26/13 stated that the patient was recommended for right sacroiliac joint rhizotomy due to the relief from sacroiliac joint injections. Physical examination at this visit demonstrated paravertebral tenderness and tenderness over the right sacroiliac joint. Follow up on 04/08/13 again recommended the patient for sacroiliac joint rhizotomy. Physical examination was unchanged from prior evaluation. The request for L4 through S3 rhizotomy was denied by utilization review on 04/19/13 as there was no specific satisfactory response from sacroiliac joint injections to support multilevel rhizotomy. The request was again denied by utilization review on 06/06/13 as there was limited evidence supporting the efficacy of

sacroiliac joint rhizotomy.

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

The patient has been followed for chronic low back pain and lower extremity pain. The patient was considered for tertiary pain management including spinal cord stimulator in 2012. The most recent interventions included a right sacroiliac joint injection in which the patient reported approximately 40% improvement from the initial injection. The most recent clinical record from 04/08/13 clarified that the patient actually received greater than 80% relief in the initial diagnostic phase with 50% pain relief lasting for a few weeks. As the available clinical literature does not definitively recommend sacroiliac joint rhizotomy due to the unclear innervation of this sacroiliac joint area, and as the patient has been previously fused from L4 through S1, rhizotomy procedures as requested from L4 to S3 times three procedures would not be supported as medically necessary. There is no indication that the patient had a significant functional response to the sacroiliac joint injections and the use of sacroiliac joint rhizotomy would not reasonably require multiple levels through fused areas from L4 to S1. As such it is the opinion of this reviewer that medical necessity is not established for the request based on guideline recommendations 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)