CALIGRA MANAGEMENT, LLC
1201 ELKFORD LANE
JUSTIN, TX 76247
817-726-3015 (phone)
888-501-0299 (fax)

Notice of Independent Review Decision

March 17, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Rhizotomy SI: Right Side

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

REVIEW OUTCOME:

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

X Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is male who on xx/xx/xx, stepped down, his leg slipped out under him. He twisted his body to prevent himself from falling.

2011: On xxxxxx, evaluated the patient for right hip pain and hip injury. The patient reported that he saw who treated him with physical therapy (PT) with improvement. took x-rays and referred the patient. The patient took Flexeril and Ultracet with some relief. He had constant dull pain that increased with movement. He had sharp pain down his right leg. He had numbness in toes and foot. The pain radiated down the leg. The pain level was 4/10. Examination showed moderate lumbar spine tenderness on range of motion (ROM), lumbar flexion was 90 degrees, extension was 10 degrees, left side bending was 10

degrees and right side bending was 20 degrees. There was positive straight leg raise (SLR) with pain radiating to the right posterior calf and heel and abnormal piriformis test on the right. Anterior aspect of the right proximal lower leg and anterior aspect of the right distal lower leg demonstrated decreased light touch sensation. The right foot plantar flexors and right foot dorsiflexors strength was 4+/5. X-rays of the lumbar spine showed 18 degrees apex curvature to the left at L4 and narrowing of L3-L4 disc space. assessed lumbar radiculopathy at L4 and L5, sciatica and scoliosis. He prescribed Medrol Dosepak and ordered a magnetic resonance imaging (MRI) of the lumbar spine.

On September 15, 2011, MRI of the lumbar spine without contrast showed: (1) Grade I spondylolisthesis of L5 on S1 due to pars defects. The central canal at this level appeared normal caliber but the subluxation and associated spondylotic changes caused narrowing of the foramen bilaterally, left a little worse than right. (2) There were degenerative disc and facet changes at L4-L5. A disc protrusion indented thecal sac centrally. Hypertrophic facet changes impinged on the lateral recesses and foramen bilaterally. There was fluid in the facet joints dorsally at this level suggesting inflammation of the facets. (3) Less pronounced degenerative disc changes at L2-L3 and L3-L4. There was a moderate scoliosis convex to the left.

On September 26, 2011, noted that the patient had completed PT with some relief. He was taking Flexeril and tramadol with relief. He complained of dull pain that increased with movement. He reported numbness and tingling in the left foot and toes. His pain level was 3/10. Examination of the lower back showed left rib hump, lumbar flexion was 75 degrees, extension was 20 degrees, left side bend was 30 degrees and right side bend was 20 degrees. The patient had lumbar pain at the extremes of motion. reviewed the MRI of the lumbar spine that showed degenerative disc disease (DDD)/ desiccation at L5-S1, L4-L5, L3-L4 and L2-L3, positive disc bulge at L4-L5 and spondylolisthesis at L5-S1 grade I and scoliosis. Diagnosis was thoracic or lumbosacral neuritis or radiculitis, unspecified, low back pain/backache/unspecified, lumbar spondylolisthesis at L5-S1 and scoliosis. prescribed Lodine and recommended PT. The patient was to continue light duty.

On October 17, 2011, evaluated the patient for lumbar radiculopathy at L4-L5. The patient reported that his back felt a little better since the last visit. He reported that PT was helping. Lodine prescribed on the last visit was also helping. He had constant pain worse with movement, numbness/tingling in the right foot/toes and pain level of 3-4/10. prescribed Lodine and recommended continuing PT.

On November 7, 2011, evaluated the patient. The patient reported feeling much better with PT. He reported soreness in the morning and ibuprofen was helping. His ROM was improved. The patient reported that overall his symptoms had decreased. The radiating pain had decreased. The numbness and tingling had remained the same. On examination, the patient had decreased lumbar ROM, decreased sensation on L5 and S1 root distribution. The Ely heel remained

positive on the right. Diagnosis was right lumbar sprain unspecified site of sprain and strain and pain in joint involving lower leg. There was additional therapy needed as the patient was advancing to the trial of full duties to continue controlling discomfort and improving mobility until the epidural steroid injection (ESI). recommended continuing PT, trial full duty and referred the patient for ESI.

On November 7, 2011, the patient was seen. The patient reported that his ROM had improved. He had constant pain worse in the morning and with quick movements. He had numbness and tingling in the foot and toes. His pain level was 1-2/10. Examination of the lumbar spine showed mild tenderness on palpation of the L4 to S1 region. Flexion was 90 degrees, extension was 20, left side bending was 20 degrees and right side was 30 degrees. The patient had lumbar pain with left tilting. He was unable to stand on right toe due to weakness in big toe. The muscle strength of the right EHL was 4/5. Diagnosis was unspecified backache, spondylolisthesis, congenital, thoracic or lumbosacral neuritis or radiculitis, unspecified. The patient was doing better but had a definite EHL weakness on the right. He had done quite bit of PT and they felt he was maxed out. He was still having radiculopathy on the right with EHL weakness. It was opined that the patient would benefit from an ESI. The patient was referred for evaluation.

On November 16, 2011, evaluated the patient for right foot numbness. The patient had some discomfort in the low back. The pain was rated at 0-2/10. recommended continuing therapy, full duty and referred the patient. A functional capacity evaluation (FCE) was recommended.

On December 12, 2011, evaluated the patient for low back pain rated at 7/10 and leg pain radiated at 4/10. The patient complained of numbing sensation that extended down his right leg into his foot. The pain would keep him awake at night. He had tried 30 plus PT sessions, which did help initially to ambulate properly, but PT had not provided any relief to his back pain. History was positive for left shoulder surgery in 1973/1974. Examination showed decreased sensation extending down the L5 dermatome into the foot. He had antalgic gait on the right secondary to the pain. The lumbar ROM was decreased in extension secondary to stiffness and pain. He had mild tenderness to palpation over the bilateral lower lumbar region, paravertebral region and sacroiliac (SI) joints. He had decreased muscle strength in the right peroneal 5-/5 and decreased strength in the right EHL. There was negative straight leg raise (SLR) on the left with positive SLR on the right for pain in his posterior buttock area without any radicular pain in his leg. MRI of the lumbar spine dated September 15, 2011, was reviewed. diagnosed spondylolisthesis, congenital at L5-S1 level, lumbosacral spondylosis with radicular syndrome, spinal stenosis and disorders of the SI joint. It was felt that the patient was candidate for a right ESI injection, selected nerve root block (SNRB) at the L5 level. Zanaflex, Mobic and tramadol were prescribed.

2012: On January 19, 2012, performed a selective nerve root block at L5 on the right side.

On February 15, 2012, noted that the steroid injection had given the patient significant relief of his leg pain, but he still had moderate low back pain. He had developed neck pain and arm pain over the last week or two while working as well. He was working full duty. He had significant pain with extension and significant tenderness to palpation over the lower lumbar paravertebral region. Diagnosis was grade I spondylolisthesis at L5-S1, lumbar spondylosis, improved lumbar radicular syndrome, spinal stenosis, disorder of the SI joint and lumbar facet syndrome. The patient was having significant low back pain that was facetogenic. refilled Mobic and Zanaflex and prescribed Norco. He recommended facet medial branch block (MBB) at L5-S1 level for therapeutic and diagnostic purpose.

On March 21, 2012, performed bilateral medical branch blocks on the facet joint at L5-S1.

On April 12, 2012, dictating noted that the patient had good success with L5-S1 facet blocks. The patient reported that he experienced 90% to 100% pain relief with the injection. He stated that his was pain free immediately following the injection and was still having some residual effect even on that visit. His low back pain was rated at 3/10. He was taking medications as prescribed. Zanaflex was refilled. Rhizotomy at the bilateral L5-S1 level was recommended. The patient had experienced greater than 70% pain relief with his MBB. He was a good candidate for further treatment with rhizotomy.

On May 17, 2012, noted that the patient was still having significant low back pain. He had a few instances of some leg pain, which he had not experiencing in quite some time. It was noted that the patient had been denied rhizotomy twice. He had failed conservative treatment measures including medication and PT which was over 30 sessions. He had also completed medial branch blocks for facet joints which gave him significant pain relief. The patient was definitely a candidate for rhizotomy. He was having increased leg symptoms. recommended follow-up in one month for further evaluation and to see if his increased leg symptoms subsided or increased.

On June 19, 2012, noted that the L5-S1 rhizotomy was again denied. He opined that the patient met the criteria for rhizotomy. The previous L5-S1 medial branch block completed gave the patient 100 % pain relief. The patient was absolute candidate for medial branch rhizotomy and he met all diagnostic criteria and ODG guidelines. resubmitted the request for bilateral medial rhizotomy of the L5-S1.

On September 6, 2012, performed the bilateral medial branch rhizotomy of the facet joint at L5-S1.

On October 2, 2012, the patient reported that the rhizotomy dated September 6, 2012, had helped with his low back pain. He was taking less pain medication. He was happy with his progress. He described some cramping in his buttocks and hamstring and calf on the right leg at times. The patient was recommended follow-up in two months for further assessment.

On December 6, 2012, the patient reported improved low back pain since his rhizotomy. He reported pain level of 3/10. He reported having some cramping in both lower extremities in the morning and sometimes later in the evening. He wanted refill of meloxicam. The patient was noted to be doing well with regards to his low back pain. He had gradual increase in cramping in his lower calf bilaterally. He did have some stenosis and instability based on his last MRI. refilled meloxicam and recommended follow-up in two months.

2013: On February 7, 2013, noted that the patient was still doing quite well after his ablation procedure. His low back pain was 2/10 in severity. He needed refills of hydrocodone. He was back to work without restrictions. refilled hydrocodone and recommended continuing meloxicam and Flexeril as needed. The patient was to follow-up in two months.

On April 4, 2013, noted that the patient was doing well. The pain was under control. The patient wanted to change Flexeril for another muscle relaxer due to leg cramping. He was still working without restrictions. recommended trying Zanaflex instead of Flexeril. He also prescribed anti-inflammatory cream. The patient was to follow-up in three months. It was noted that the patient had a great result from the rhizotomy.

On July 11, 2013, noted that the pain was controlled with medication. The patient would like to try a different muscle relaxant. He felt the Zanaflex caused his legs shake. Zanaflex was changed to Robaxin. The patient was given two refills of hydrocodone. The patient was to follow-up in three months.

On October 7, 2013, the patient requested a refill of Robaxin. The patient reported he had return of his right SI joint pain and this had started to affect his ability to work. Examination showed significant tenderness to palpation over the right SI joint with positive Faber. Mr. recommended a right SI joint injection. If the patient had positive results with this then proceeding with her right SI joint rhizotomy. The patient was given refills of Robaxin.

On November 14, 2013, performed right SI joint injection, right SI joint arthrography and right paraspinal lumbar myofascial trigger point injection (TPI)/one muscle.

On December 26, 2013, noted that the patient had completed his SI joint injection. This provided greater than 75% pain relief for several days. His pain had gradually returned. The patient would like to follow through with a rhizotomy. He did not need any medications refills. Examination showed significant tenderness to palpation over the right SI joint with positive Faber. opined that the patient might be a good candidate for a SI joint rhizotomy. The patient was to follow-up in three months.

2014: Per utilization review dated January 2, 2014, the request for a right SI rhizotomy was denied with the following rationale: *"The request for a right SI*

rhizotomy (#64635) is not medically necessary. The patient has only one provocative SI maneuver documented on exam so this falls short of ODG requirements for treatment directed at the SI joint. Radiofrequency ablation (RFA) of the SI joint is considered an experimental/investigational procedure and has no proven efficacy per the literature due to a lack of sufficient medical research on this topic. Since the injection is not medically necessary, sedation is not medically necessary."

Per the reconsideration review dated January 13, 2014, the appeal for right SI rhizotomy with sedation was denied with the following rationale: *"The patient is status post a right SI joint injection that provided greater than 75% pain relief for several days. It is noted on the operative report, that on the same day, right paraspinal lumbar myofascial trigger point injections were given also. The pain has gradually returned. The request is now for a right sided SI rhizotomy. ODG does not recommend this procedure. Also, there is no criteria for sedation in ODG (pain chapter) for this procedure. Sacroiliac (SI) Rhizotomy, Right Side (#64635) is not medically necessary and appropriate. The ODG does not recommend SI joint radiofrequency neurotomy."*

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

The SIJ rhizotomy is an incomplete procedure which does not address SIJ anterior innervation and is thus not a reasonable procedure and is not supported by the ODG.

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

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES