P-IRO Inc.

An Independent Review Organization
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DATE OF REVIEW: MAY 14, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Bilateral facet injections / chemical rhizotomies at L3-4, L4-5, L5-S1.

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

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 or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Office note, Dr. 09/25/06 and 01/03/07
NCS, 12/12/06
CT myelogram, 12/18/06
Office notes, Dr. 03/19/07 and 04/19/07
Peer review, Dr. 03/30/07
Peer review for second level appeal, undated
Letters 04/03/07, 04/16/07 and 04/27/07
Notation of peer review, 04/03/07
Office note, Dr. 04/16/07
Medical conference e 04/16/07

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male injured with a subsequent L5-S1 hemilaminectomy. He apparently did well and returned to full activity. He was lifting and twisting and developed low back pain. A 12/12/06 NCS documented L5 and S1 bilateral radiculopathy with acute denervation. A 12/18/06 myelogram CT showed L2-3 and L3-4 marginal osteophytes, L5-S1 bony osteophytes and mild endplate subchondral sclerosis.

On 03/19/07 Dr. evaluated the patient and noted that the patient had therapy and acupuncture with some benefit. He was noted to have had lumbar facet blocks at L3 through S1 on 02/13/07 with 60-70 percent relief. He experienced gastrointestinal upset with anti-inflammatories and other treatment included work restrictions. On examination he was mildly tender over the joints. Forward flexion was to 45 degrees and extension 5 degrees with low back pain. Straight leg raise was positive bilaterally at 45 degrees for low back pain. Reflexes and sensation were normal. An MRI of 10/06 reportedly showed reactive endplate edema subadjacent to the endplates at L5-S1 articulation and anterior-inferior endplate at L2. There was also facet arthrosis and effusion indicating posttraumatic anti-inflammatory reparative changes. L3-4, 4-5 and L5-S1 bilateral facet rhizotomy was recommended.

A 04/16/07 visit with Dr. neurology showed examination findings of decreased motion, decreased strength in the right leg with decreased sensation on right and a decreased right ankle jerk. His impression was lumbar radiculopathy of L4-S1 and he recommended Ultram, Soma, Darvocet, Lyrica and facet injections.

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

Bilateral facet injections / chemical rhizotomies at L3-4, L4-5, L5-S1 do not appear to be medically necessary per Official Disability Guidelines for Texas. No more than two joint levels are to be performed at any one time and there should be evidence of a formal plan with additional evidence based conservative care in addition to facet joint therapy. There is question about whether or not this patient had ankylosing spondylitis and HLA-B27 is being obtained. It is unclear whether or not these facets may or may not be the origin of this patient's pain and symptomatology. Lumbar facet blocks at L3 through S1 on 02/13/07 with a 60 to 70 percent relief. Gastrointestinal side effects to anti-inflammatories are noted. Based upon the guidelines and a careful review of all the medical records, the Reviewer's medical assessment is that the bilateral facet injections / chemical rhizotomies at L3-4, L4-5, L5-S1 is not medically necessary.

Official Disability Guidelines Fifth Edition Treatment in Worker's Comp 2007 Update, Low back-Facet joint radiofrequency neurotomy "Under study. Conflicting evidence does not allow for a recommendation. Studies have not demonstrated improved function. Also called Facet rhizotomy, Radiofrequency medial branch neurotomy or Radiofrequency ablation (RFA), this is a type of injection procedure in which a heat lesion is created on specific nerves to interrupt pain signals to the brain, with a medial branch neurotomy affecting the nerves carrying pain from the facet joints."

Criteria for use of facet joint radiofrequency neurotomy:

1. Treatment requires a diagnosis of facet joint pain.
2. While repeat neurotomies may be required, they should not occur at an interval of less than 6 months from the first procedure. A neurotomy should not be repeated unless duration of relief from the first procedure is documented for at least 12 weeks at ≥ 70% relief.
3. Approval of repeat neurotomies depends on variables such as evidence of adequate diagnostic blocks, documented improvement in VAS score and documented improvement in function.
4. No more than two joint levels are to be performed at one time.
5. If different regions require neural blockade, these should be performed at intervals of no sooner than one week, and preferably 2 weeks for most blocks.
6. There should be evidence of a formal plan of additional evidence-based conservative care in addition to facet joint therapy.

A 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)**