



Notice of Independent Review Decision

DATE OF REVIEW: 6/27/08

IRO CASE #: **NAME:**

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for thoracic facet joint nerve rhizotomies at T9-T11 left.

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

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.

The previously denied request for thoracic facet joint nerve rhizotomies at T9-T11 left

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Referral Form (unspecified date).
- Request for a Review by an Independent Review Organization dated 6/11/08.
- Fax Coversheet/Authorization Request dated 6/10/08.

- Notice of Determination dated 5/30/08, 5/22/08.
- Review Summary dated 5/21/08.
- Peer Review dated 5/30/08, 4/14/08.
- Notice to of dated 6/23/08.
- Letter of Medical Necessity dated 5/16/08, 4/9/08.
- Office Evaluation dated 5/9/08, 3/26/08, 12/21/07, 11/28/07, 7/9/07, 4/16/07.
- Operative Procedure Notes dated 4/25/08, 11/12/07, 1/10/07.
- Prescription dated 3/26/08.
- Letter of Appeal dated 5/30/08.

PATIENT CLINICAL HISTORY (SUMMARY):

Age: xx years

Gender: Male

Date of Injury: xx/xx/xx

Mechanism of Injury: Lifting injury

Diagnosis: Thoracic pain, lumbar pain post-lumbar fusion, cervical pain, and sacroiliac joint with myofascial pain syndrome.

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

Per available documentation, this is a xx-year-old male with an industrial injury on xx/xx/xx. The mechanism of injury was lifting . The current diagnosis was thoracic pain, lumbar pain post-lumbar fusion, cervical pain, and sacroiliac joint pain with myofascial pain syndrome. The claimant was noted to have undergone lumbar surgery in 2001 and 2003. The claimant had undergone comparative thoracic facet joint injections in January and November of 2007. Each of these blocks produced temporary relief of the patient’s pain – 50% and 70% respectively. The claimant then underwent right T9-T11 radiofrequency neurotomy 4/25/08 which apparently provided 50% relief (per note from provider). On recent exam the claimant had tenderness to palpation (TTP) over the bilateral thoracic facet joints with muscle spasms and radiculopathy. There was also lumbar facet tenderness and sacroiliac joint tenderness bilaterally. He was noted that he complained of pain in the cervical, thoracic, and lumbar regions. Per ODG guidelines states the following: “Criteria for use of facet joint radiofrequency neurotomy: (1) Treatment requires a diagnosis of facet joint pain using a medial branch block as described above....Criteria for use of therapeutic intra-articular and medial branch blocks, are as follows: (3). If successful (pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive).” In this case, the claimant has undergone comparative facet joint injections – not medial branch blocks (see operative reports). The ODG Guidelines specifically requires that the diagnosis be

confirmed by medial branch block. Therefore, the recommendation is for adverse determination.

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

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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.

The Official Disability Guidelines (ODG), Treatment Index, 6th Edition (Web), 2008, Cervical-Rhizotomy.

- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).