

Clear Resolutions Inc.

An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: JUNE 9, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Open rhizotomy of T8 and T9 with one to two day inpatient stay.

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

M.D., 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.

The reviewer finds there is not medical necessity for open rhizotomy of T8 and T9 with one to two day inpatient stay.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 4/30/08, 5/15/08
ODG Guidelines and Treatment Guidelines
Operative report, 11/07/2006
Office note, Dr. , 04/10/08
Office note, Dr., 02/14/07, 04/23/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This xx year old claimant was diagnosed with a compression fracture of T8 and was status post kyphoplasty January 2006 followed by a corpectomy of T8 and fusion T7 to T9 with additional fixation in November 2006. The claimant was noted to have ongoing pain despite medications, therapy and intercostal injections. An open rhizotomy T8 and T9 was requested.

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

Based on review of this medical record, the reviewer finds that open rhizotomy T8 and T9 with one or two day length of stay is not medically reasonable and necessary.

The medical record indicates this person has back and radicular leg pain, and although there was improvement with intercostal injections, it is not clear if these injections were, in fact, facet injections or were just possibly injections into the intercostal space.

ODG guidelines document improvement with diagnostic blocks, but in this case, it is not clear that this person, in fact, did undergo a facet-type of block or a block of the ramus area, which might indicate a better chance of improvement following radiofrequency neurotomy. It is also not clear why this is requested as an open procedure and not a percutaneous procedure. Therefore, this is not medically reasonable and necessary based on this medical record.

Official Disability Guidelines Treatment in Worker's Comp 2007 Updates, Neck and Upper back:
Facet joint radiofrequency neurotomy

Milliman Care Guidelines . Inpatient and Surgical Care 12th Edition.

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)**