



Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 12/1/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of left L4-L5 and L5-S1 facet rhizotomy.

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. The reviewer has been practicing for greater than 15 years and performs this type of service in daily practice.

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)

The reviewer disagrees with the previous adverse determination regarding the prospective medical necessity of left L4-L5 and L5-S1 facet rhizotomy.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:

PATIENT CLINICAL HISTORY [SUMMARY]:

Records from xxxxx reflect treatment for ongoing back pain. The patient was noted to have undergone a lumbar rhizotomy in October of 2004 with significant pain relief. The patient's past medical history also included surgical artificial disk replacement at L4-L5 and L5-S1. On examination, painful spinal extension and "facet-loading" were noted to cause significant back pain. In August of 2009, the patient underwent a facet rhizotomy with significant relief on the right side however without any significant left-sided pain relief. The patient reported complete resolution of pain on the right side in September of 09, albeit without any pain relief on the left side. Temporizing facet injections were administered in September of 09, with dramatic but temporary left-sided pain relief, with

dramatic but temporary left-sided pain relief. The patient was considered for repeat rhizotomies, left-sided.

The 10/5/09 and 10/19/09 dated letters of non-certification were noted to reflect rationale indicating the lack of efficacy from the prior left-sided rhizotomy, the unknown effects of the subsequent facet injections and/or lack of effects of conservative care.

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

The submitted documentation does meet the intent of the *Official Disability Guidelines'* section with regards to facet rhizotomy criteria. When viewed in unreasonable isolation, the guidelines would appear to not support a repeat rhizotomy due to a lack of initial left-sided rhizotomy response. However, the guidelines support viewing indications for this procedure on a "case by case" basis. The patient had a distant history of a positive response to rhizotomy in 2004. The patient has had an excellent response to the right-sided rhizotomy and a short-lived but now documented efficacious response to the left sided (post-ineffective rhizotomy) facet injections, supporting the left-sided facets as ongoing pain generators. The patient has had reasonable documentation of failure of conservative care overall. With very similar anatomic circumstances of persistent L4-L5 and L5-S1 artificial disc constructs, the anatomic local effects on the right and left sides of both spinal levels are persistent and ongoing. The patient has limited options and in effect should not be "penalized" by the one-time lack of rhizotomy response on the left, especially when the right sided rhizotomies and the prior left-sided 2004 rhizotomy procedures have been efficacious. The patient has an indication for the left-sided rhizotomy on a prospective basis in order to provide him another reasonable attempt to achieve the efficacy that has been noted on the contralateral right side at both levels.

This reviewer's opinions have been based on clinical experience and both the *Official Disability Guidelines* web-based guidelines and *The American College of Occupational and Environmental Medicine*, Second Edition, practice guidelines, from the chapters related to the low back, including the section on Special Studies, Diagnostics, and Treatment.

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)