



514 N. Locust St.
Denton, TX. 76201
Off: (940) 382-4511
Fax: (940) 382-4509
Toll Free: (877) 234-4736

Notice of Independent Review Decision

DATE OF REVIEW: 03/23/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Facet Joint Rhizotomy

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

Board Certified in Physical Medicine & Rehabilitation

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

- Chest x-ray, M.D., xx/xx/xx
- Pelvis x-ray, Dr. xx/xx/xx
- Left knee, lower leg, ankle, foot x-rays, M.D., xx/xx/xx
- Right knee, ankle, lower leg, foot x-rays, Dr. xx/xx/xx
- Left shoulder x-ray, M.D., xx/xx/xx

- Physician's Order Sheet, Unknown Provider, xx/xx/xx
- Physician's Orders for Trauma Room Resuscitation, Unknown Provider, xx/xx/xx
- Orthopaedic Admission/Consultation, Unknown Provider, xx/xx/xx
- Emergency Department Clinician Record, Unknown Provider, xx/xx/xx
- Trauma Services Department Admit Note, Unknown Provider, xx/xx/xx
- Radiology Imaging Request, Unknown Provider, xx/xx/xx
- Initial Medical Examination, M.D., 04/16/07
- MRI of the left foot, M.D., 04/18/07
- MRI of the left ankle, Dr. 04/18/07
- Left tibia and fibula x-rays, M.D., 04/18/07
- Left femur x-ray, Dr. 04/18/07
- Follow up Examination, Dr. 04/23/07
- Follow up Examination, Dr. 05/10/07
- Follow up Examination, Dr. 05/24/07
- Follow up Examination, Dr. 06/07/07
- Evaluation and Consultation, Ph.D, 06/08/07
- Follow up Examination, Dr. 08/27/07
- Follow up Examination, Dr. 09/21/07
- Individual Psychotherapy and Behavioral Pain Management, Dr. 10/03/07
- Follow up Examination, Dr. 10/10/07
- Follow up Examination, Dr. 12/10/07
- Follow up Examination, Dr. 01/02/08
- Physical Performance Evaluation Review, Dr. 01/03/08
- Lumbar Epidural Steroid Injection, Dr. 01/16/08
- Follow up Examination, Dr. 01/21/08
- Follow up Examination, Dr. 02/04/08
- Right L4-5 and right L5-S1 paravertebral facet injection, Dr. 02/18/08
- Recovery Room Note, Dr. 02/18/08
- Follow up Examination, Dr. 02/25/08
- Left S1 joint, Dr. 03/03/08
- Follow up Examination, Dr. 03/03/08
- Functional Capacity Evaluation, Unknown Provider, 03/14/08
- Request for Functional Capacity Evaluation, Dr. 03/16/08
- Follow up Examination, Dr. 03/17/08
- Follow up Examination, Dr. 04/02/08
- Maximum Medical Improvement and Impairment Rating, Dr. 04/04/08
- Individual psychotherapy, Dr. 04/11/08
- Follow up Examination, Dr. 05/19/08
- Follow up Examination, Dr. 06/25/08
- Letter to Dr. Drazner from Dr. 07/28/08
- Follow up Examination, Dr. 09/24/08
- Request for Preauthorization, Dr. 10/01/08
- Individual psychotherapy, Dr. 11/12/08
- Follow up Examination, Dr. 12/08/08

- Follow up Examination, Dr. 01/19/09
- UR Denial, M.D. 01/30/09
- Follow up Examination, Dr. 02/04/09
- UR Denial, M.D., 02/11/09
- Individual Psychotherapy, Dr. 02/13/09
- Medical Director Review (UR), Managed Care, 01/30/09, 02/11/09
- Undated List of Providers Who Have Treated
- Health & Hospital System, Reconsideration Request, xx/xx/xx
- The ODG Guidelines were not provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient was injured on xx/xx/xx when he fell from a height of approximately three stories, injuring multiple regions of his body including the right elbow, left shoulder, lumbar spine, facial region and left foot. He has had multiple x-rays, an epidural steroid injection, and MRIs of the left foot and ankle. Current medications include Mobic and Percocet.

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

Based upon the records available for review, medical necessity for treatment in the form of a lumbar facet rhizotomy would not appear to be of medical necessity for the following reasons:

Per the criteria set forth by the Official Disability Guidelines, it is documented that treatment in the form of a facet joint radiofrequency neurotomy procedure is actually “currently under study.” There is conflicting evidence available with respect to the efficacy of this procedure.

The records available for review do document that there are symptoms consistent with a lumbar facet mediated pain syndrome. However, the records available for review do not document that a lumbar MRI has been accomplished since the date of injury to fully evaluate pain symptoms referable to the lumbar region.

To establish a diagnosis of a facet mediated pain syndrome, there must be documentation to indicate that therapeutic injections have decreased pain symptoms. The records available for review would appear to indicate that the claimant underwent only a right-sided lumbar facet injection on 02/18/08. There was no documentation to indicate that there was ever an injection performed to the left side of the lumbar region. The current request would appear to be for a lumbar facet rhizotomy procedure to the bilateral L5-S1 level.

An extensive amount of medical documentation was reviewed. As stated above, the records available for review do indicate that there were findings on physical examination that were consistent with a possible lumbar facet mediated pain syndrome. However, as

stated above, it would not appear that a lumbar MRI study has been accomplished to objectively re-evaluate the lumbar spinal anatomy and, also, it would appear that the only facet injections ever performed to the lumbar spine were accomplished on 02/18/08. There is no documentation to indicate that a confirmatory injection was ever pursued, and there is no documentation to indicate that there was ever an attempt at a diagnostic injection to facet joints on the left side in the lumbar region. Hence, based upon the extensive medical records currently available for review, medical necessity for treatment in the form of a lumbar facet rhizotomy as requested would currently not appear to be established as one of medical necessity per criteria set forth by ODG Guidelines.

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)