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## Notice of Independent Review Decision

### IRO REVIEWER REPORT – WC (Non-Network)

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**DATE OF REVIEW:** 02/23/11

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Right L4-L5 and L5-S1 rhizotomy

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

Board Certified in Orthopedic Surgery

**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.

Right L4-L5 and L5-S1 rhizotomy - Upheld

## **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

An evaluation with physician dated 02/26/10  
A physician activity status report dated 02/26/10  
DWC-73 forms dated 02/26/10 and 05/26/10  
Evaluations with M.D. dated 03/03/10, 03/24/10, 05/19/10, 06/17/10, 07/19/10, 08/12/10, 08/26/10, 09/23/10, 10/26/10, and 11/16/10  
A physical therapy prescription dated 03/03/10  
A medical review dated 03/05/10  
A physical therapy evaluation dated 03/18/10  
A plan of care dated 04/05/10  
A Functional Capacity Evaluation (FCE) dated 04/16/10  
A Designated Doctor Evaluation dated 05/10/10  
An FCE dated 05/12/10  
A prescription for bilateral SI joint injections dated 05/19/10  
An MRI of the lumbar spine dated 11/09/10  
Evaluations dated 12/02/10, 01/17/11, 01/24/11, and 01/31/11  
A procedure note dated 12/27/10  
A letter of non-certification, according to the Official Disability Guidelines (ODG), dated 01/24/11  
A letter of non-certification, according to the ODG, dated 02/07/11  
A letter from attorney at law dated 02/15/11  
The ODG Guidelines were not provided by the carrier or the URA

## **PATIENT CLINICAL HISTORY**

On 02/26/10, Dr. recommended light work duty, physical therapy, Celebrex, and Flexeril. On 03/03/10, Dr. recommended stabilization exercises and off work status. Physical therapy was recommended on 03/15/10. An FCE on 04/16/10 indicated the patient functioned at the light-medium physical demand level and physical therapy was recommended. On 05/10/10, placed the patient at Maximum Medical Improvement (MMI) with a 5% whole person impairment rating. An FCE with on 05/12/10 indicated the patient had been discharged from work hardening. On 05/19/10 and 06/17/10, recommended further work conditioning and work hardening. On 07/19/10, stated he disagreed with the Designated Doctor on MMI. On 10/26/10, recommended an SI rhizotomy. An MRI of the lumbar spine on 11/09/10 showed disc protrusions at L3-L4, L4-L5, and L5-S1. Bilateral L4-L5 and L5-S1 facet joint medial branch nerve blocks were performed on 12/27/10. On 01/17/11, recommended a lumbar facet rhizotomy. On 01/24/11, wrote a letter of non-certification for a lumbar L4-L5 rhizotomy. On 01/31/11, noted the patient was disputing his MMI. On 02/07/11, also wrote a letter of non-certification for the rhizotomy.

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

The patient does not meet the Official Disability Guidelines (ODG) criteria for proceeding with a rhizotomy. The patient has had one set of medial branch blocks. The other set of branch blocks were performed in the sacrum. Both provided equal pain relief. There is no clear evidence that we have identified the pain generator and there has not been a second set of branch blocks as required by the ODG prior to proceeding with rhizotomy. A set of confirmatory branch blocks, using different local anesthetic, hopefully with a different length of relief of pain, would confirm that this is not a placebo response in a chronic pain patient. Therefore, at this time, the requested right L4-L5 and L5-S1 rhizotomy is neither reasonable nor necessary and the previous adverse determinations should be upheld.

**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 AND KNOWLEDGE BASE
- 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)**