

SENT VIA EMAIL OR FAX ON
Jun/23/2011

True Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jun/21/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

O/P Lumbar Rhizotomy

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

M.D., Board Certified in Anesthesiology and Pain Management

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

1. Designated doctor evaluation dated 11/02/10
2. Clinical records Dr. dated 12/09/09 and 12/15/09
3. MRI lumbar spine dated 01/07/10
4. Clinic note Dr. dated 05/12/10-04/13/11
5. Radiographic report lumbar spine dated 05/12/10
6. Procedure report bilateral selective nerve root block at L4-5
7. Clinical records Dr. 09/18/10-05/03/11
8. Procedure report lumbar facet joint injections L5-S1 dated 12/23/10
9. Utilization review determination dated 05/12/11
10. Utilization review determination dated 06/03/11

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a XX year old male who is reported to have sustained work related injuries on XX/XX/XX. It is reported on the date of injury he was working on a platform pushing heavy items when he slipped and fell in the mud. He turned his body to prevent from falling face down and instead fell on his back. He was originally seen in local emergency department on XX/XX/XX with low back pain radiating into left lower extremity. He later came under the care of Dr. who diagnosed lumbar contusion and lumbar pain. Radiographs of lumbar spine showed mild degenerative changes. MRI of lumbar spine dated 01/07/10 showed degenerative disc disease evidenced by desiccation and minimal to mild disc bulging, facet joint arthropathy at L5-S1 with no disc herniation or significant spinal or foraminal stenosis.

On 05/12/10 the claimant was seen by Dr.. He has complaints of low back pain with radiation of left lower extremity with weakness in left tibialis anterior. On physical examination he is reported to weigh XXX lbs. He has left tibialis anterior weakness graded as 4/5. The remainder is intact. Reflexes are diminished in left patella tendon compared to right. On straight leg raise he reports left leg pain with mild radiating pain going down the left hip region. He is opined to have left L4-5 radiculopathy and subsequently is recommended to undergo lumbar epidural steroid injection. Lumbar flexion / extension radiographs were performed at this visit and showed no evidence of instability.

On 07/26/10 the claimant underwent bilateral selective nerve root blocks and steroid injections at L4-5 level. He was subsequently seen in follow-up on 08/04/10 in which he reports a reduction with pain to

4-5/10. The second day following injection his symptoms began to return. He reported a catch in his back when he moves from sitting to standing. He subsequently was recommended to be seen by pain management for evaluation at L4-5, L5-S1 facet mediated nerve root pain. It was opined the claimant is not a surgical candidate.

On 09/18/10 the claimant was seen by Dr.. He presents with complaints of low back pain with radiation of left lower extremity. On physical examination he is noted to be X"X" and weighs XXX lbs. Motor strength is reported to be intact. Deep tendon reflexes are absent. There is no obvious sensory deficit. He was provided oral medications and recommended to undergo L5-S1 bilateral facet joint injections. He was further started on Klonopin. The record includes a pain diagram in which the claimant has focal pain at lumbosacral junction with radiation down posterior aspect of left lower extremity. The claimant was seen in follow-up on 11/17/10. He has had no change in pain intensity graded as 8/10. He is reported to not be getting any sleep. There is no detailed physical examination.

On 12/23/10 the claimant underwent lumbar facet joint injections. Post procedurally the claimant was seen in follow-up on 02/23/11. He is reported to have had improvement for 7-10 days. He is noted to be hypertensive. It is reported that he has pain with flexion and extension. Straight leg raise is reported to be positive at 30 degrees. He did not do lateral rotation in that it exacerbates his pain.

On 04/13/11 the claimant was seen in follow-up by Dr.. It is reported the claimant has previously undergone injections with temporary improvement. 8 days later he developed an increase in his symptoms again. He reported significant amount of pain and numbness radiating into left lower extremity. He continues to have tibialis anterior weakness graded 4/5. It is reported that Dr. has recommended rhizotomy. Dr. has agreed with this plan.

On 05/03/11 the claimant was seen in follow-up. He presents for refills of his medications. His pain level is reported to be 9/10. A request was placed for lumbar facet rhizotomy.

On 05/12/10 this request was reviewed by Dr.. Dr. non-certifies the request, reporting that the records do not contain a recent comprehensive clinical assessment of the injured employee that addresses the proposed service. He reports there's no documentation provided with regard to the failure to respond to conservative management. He reports there are no progress notes from physical therapy and that the records do not include detailed data regarding the injured employee's clinical and functional response from the previous facet injections. Appeal request was submitted and reviewed by Dr. on 06/03/11. Dr. non-certified the request. He notes that the medical records did not provide objective documentation to confirm whether or not the injured employee has failed conservative management. He notes that there is no mention in the follow up reports whether a formal plan of additional evidence based conservative management such as physical therapy was planned in addition to this request. It is opined that the request is not substantiated.

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

The request for outpatient lumbar rhizotomy is not supported by the submitted clinical information. The available clinical records indicate that the injured employee has a history of low back pain with radiculopathy that appears unresponsive to epidural steroid injections. On imaging studies he's noted to have facet arthropathy at the L5-S1 level. The records indicate that the injured employee ultimately underwent facet injections. He is reported to have had approximately eight days of improvement in his symptoms. The records do not indicate that the injured employee underwent a confirmatory medial branch block. While there is documentation of transient improvement with facet injections; under current evidence based guidelines, facet injections must be confirmed by medial branch blocks to establish the diagnosis of facet mediated pain. It is further noted that the performance of facet rhizotomy should be in conjunction with an evidence based exercise program to further the injured employee's rehabilitation goals. In the absence of documentation establishing the failure of conservative care and noting the absence of confirmatory medial branch blocks, the request cannot be considered medically necessary. It is therefore opined that the previous utilization review determinations were appropriate and consistent with current evidence based recommendations and therefore are upheld.

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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES