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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:
Sep/28/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Outpatient Bilateral Lumbar Rhizotomy L4/S1

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Board Certified Anesthesiologist
Board Certified Pain Medicine

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[ ] Upheld (Agree)

[X] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
ODG - Official Disability Guidelines & Treatment Guidelines
Request for IRO 09/14/12
Utilization review determination 07/24/12
Utilization review determination 09/04/12
MRI lumbar spine 01/10/06
Procedure report 02/14/06
Procedure report lumbar epidural steroid injection 02/27/06
CT myelogram 04/07/06
Procedure report facet injections 12/12/06
Procedure report facet injections 01/16/07
Procedure report RFTC 04/03/07
DWC form 69 01/24/08
Designated doctor evaluation 01/24/08
Physical therapy treatment records
Procedure report facet injections 09/07/11
Clinical records
Clinical records 11/01/11-07/03/12
Psychological interview 06/11/12
TPE evaluation 06/11/12

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a male who is reported to have sustained an injury to his low back as result of lifting on xx/xx/xx. The record includes an MRI of the lumbar spine dated 01/10/06. This study notes mild degenerative disease at the L1-2 and L4-5 level with a generalized disc bulge at L4-5 and mild spinal canal and bilateral recess stenosis at the L5-S1 level there is a focal signal abnormality near the left lateral recess the differential diagnosis would include a synovial cyst or traumatic focal hemorrhage. The claimant was recommended to undergo CT myelography for further assessment. Additional records indicate that the claimant underwent a series of epidural steroid injections. The record contains a CT myelogram dated 04/07/06 which was felt to be largely unremarkable. There was unilateral pars defect at the L5 level on the patient's left. It is noted that there is facet arthropathy at this level.

Records indicate that the claimant's treatment focused on facet arthropathy and he underwent a series of facet injections on 12/12/06 and 01/16/07. The claimant's response to this was such that he underwent facet rhizotomy from L4 through S1 on 04/03/07.

The records further indicate that the claimant participated in a functional restoration program called the COPE program.

On 09/07/11, the claimant underwent bilateral L4-5 and L5-S1 facet injections it is reported his back pain went from 6-2/10 during anesthetic phase. He did not get any significant benefit during corticosteroid phase. He is noted to have had previous rhizotomy which provided him some relief for several months and then came back. He subsequently was recommended to undergo rhizotomy. It was noted he would be outlier to ODG guidelines.

On 11/01/11 the claimant was seen in follow-up. It is noted he has previously undergone rhizotomy in 2007 at L4-5 and L5-S1 with moderate improvement in symptoms graded as 50-60% for 6 months. He recently underwent facet injections on 09/07/11 which decreased pain from 6/10 to 1-2/10 for approximately 1 day then returned to baseline level. opines the claimant would be repeat L4-5 and L5-S1 facet rhizotomy. It was noted his initial request for rhizotomy was not approved. The claimant was later seen on 06/11/12. is pain management specialist who subsequently supports recommendation for lumbar rhizotomy.

The initial review was performed. non-certified the request noting comprehensive physical and neurological examination was not documented. The next medical report with a physical examination of the patient was dated 03/20/12 and showed an obese individual with intact strength and some tenderness over the lumbosacral junction. No recent documentation of tenderness over the targeted facet joint levels or straight leg raise test and sensory examination to rule-out radiculopathy was provided. There were no recent or ongoing active rehabilitation efforts directed to the lumbar spine submitted for review. There were no recent medial branch blocks to confirm the diagnosis of facet joint pain.

The appeal request was reviewed on 09/04/12. non-certified the request noting previous non-certification was due to lack of documentation of comprehensive physical and neurologic examination, the absence of documentation regarding tenderness over targeted facet levels and negative straight leg raise. notes in absence of comprehensive physical examination the request cannot be supported as medically necessary.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The request for outpatient bilateral lumbar rhizotomy L4-S1 is medically necessary and prior utilization review determinations are overturned. The submitted clinical records indicate the claimant has chronic history of low back pain and has previously undergone lumbar facet injections followed by rhizotomy with 50-60% relief. The claimant has been identified as having developed recurrent back pain consistent with facet mediated disease. Noting historically the claimant has undergone medial branch blocks and subsequent rhizotomy with greater than 6 months benefit there is no clinical need for reestablishing the diagnosis as it was previously made through prior treatments and procedures. This would represent

redundant diagnostic studies and treatment. Therefore, based on submitted clinical information there is evidence of active posterior element disease that has previously been responsive to facet injections as rhizotomy. Therefore, based on data provided the request is medically necessary and prior determinations are overturned.

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

[ ] ACOEM-AMERICA 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

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

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)