

IRO Express Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Jul/22/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar Spine Medial Branch Rhizotomy at L4-S1 Bilateral

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

Board Certified Orthopedic Surgeon (Joint)

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:

ODG - Official Disability Guidelines & Treatment Guidelines

Clinical notes dated 01/31/13 – 05/21/13

MRI of the lumbar spine dated 02/27/13

Procedural note dated 04/02/13

Therapy notes dated 01/17/13 – 02/18/13

Previous utilization reviews dated 05/30/13 & 06/14/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who was noted to have complaints of low back pain. The MRI of the lumbar spine dated 02/27/13 revealed a broad 1mm disc protrusion at L4-5 with right facet joint effusion. A broad 2 to 3 mm osteophyte disc protrusion was also noted at L5-S1. The therapy note dated 02/18/13 details the patient having completed 12 physical therapy sessions to date. The clinical note dated 03/07/13 details the patient complaining of ongoing low back pain. Upon exam, the patient was able to demonstrate 5/5 strength throughout the lower extremities. No reflex deficits were noted. No sensation deficits were noted. The procedural note dated 04/02/13 details the patient undergoing a facet injection from L4 to S1 bilaterally. The clinical note dated 04/16/13 details the patient presenting for a follow up regarding the facet injections. The note details the patient stating the injections provided no significant benefit or reduction in pain. The clinical note dated 05/21/13 details the patient continuing with the use of pharmacological interventions for ongoing pain relief. This clinical note states the patient received significant benefit from the previous injection. However, the patient did note a return to her baseline level. Pain and tenderness were noted at the L4-5 and L5-S1 levels.

The previous utilization review dated 05/30/13 regarding the request for a medial branch block rhizotomy at L4 through S1 bilaterally resulted in a denial secondary to the patient

reporting no significant benefit from the previous diagnostic blocks.

The previous utilization review dated 06/14/13 resulted in a denial for a L4 through S1 rhizotomy secondary to no information being provided regarding the patient's positive response to the medial branch block.

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

The documentation details the patient having significant complaints of pain in the low back. A medial branch rhizotomy would be indicated in the lumbar region provided the patient meets specific criteria to include a successful diagnostic block with a positive response. There is conflicting information regarding the patient's response to the previous diagnostic block, whereas 1 clinical note details the patient responding with no significant benefit. However, a later clinical note does detail the patient subjectively stating that she had received some benefit. However, no information was submitted regarding the patient's objective functional response regarding the previous diagnostic block to include a reduction in a VAS scale or range of motion improvements. Given that no information was submitted regarding the patient's objective clinical findings indicating a positive response to the previous diagnostic block, this request is not indicated as medically necessary. As such, it is the opinion of this reviewer that the request for a lumbar spine medial branch block rhizotomy at L4 through S1 bilaterally is not recommended as medically necessary.

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

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)