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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/27/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: bilateral L4-5 rhizotomy

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified 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 medical necessity exists for each health care service in dispute. It is this reviewer's opinion that medical necessity for bilateral L4-5 rhizotomy is not established as the request does not meet guideline recommendations.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Procedure reports dated 07/31/12 – 04/09/13
Operative report dated 04/17/00
Clinical notes dated 09/04/03 – 05/20/13
Radiographs of the lumbar spine dated 03/08/13
Required medical evaluations dated 03/11/13 & 04/05/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female who sustained an injury on xx/xx/xx. The patient is noted to be status post decompressive laminectomy followed by lumbar fusion at L5-S1. Postoperatively, the patient reported ongoing complaints of low back pain with numbness present in the left lower extremity. Prior interventional procedures have included a left sacroiliac joint injection completed on 07/31/12 as well as sacral medial branch rhizotomy from S1 to S3 completed on 12/26/12. The clinical report from 03/04/13 indicates that the patient had a prior fusion from L4-5 to L5-S1. Radiographs performed on 03/08/13 showed fusion only at L5-S1. The patient reported no significant relief with prior sacroiliac joint rhizotomy. The patient continued to report chronic low back pain radiating to the lower extremity with associated numbness and tingling. Physical examination at this visit demonstrated a slow and purposeful gait. Lumbar range of motion was restricted with pain reported on flexion and extension as well as rotation. The patient was recommended for bilateral facet joint injections at L4-5 at this visit. The patient did undergo a bilateral L4-5 facet joint block on 04/09/13. Based on the procedure report, the intraarticular facet spaces were visualized and injected. Follow up on 04/23/13 reported temporary relief, unspecified from the facet injections. The patient was then recommended for medial branch rhizotomy at L4-5. Follow up on 05/20/13 indicated relief with facet injections; however, no specifics were provided.

The request for an L4-5 rhizotomy bilaterally was denied by utilization review on 06/11/13 as facet joint blocks were performed, but not diagnostic medial branch blocks.

The request was again denied by utilization review on 07/24/13 as there were no updated physical examination findings to corroborate the L4-5 facets as pain generators. There was also no documentation regarding diagnostically positive medial branch blocks.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The clinical documentation submitted for review documents the patient having ongoing chronic low back pain following a lumbar fusion only at L5-S1. The patient was recommended for facet joint blocks which were performed at L4-5 intraarticularly at L4-5 on 04/09/13. Given that there was no documentation regarding medial branch blocks directed at the L3 and L4 medial branch nerves, the proposed bilateral L4-5 rhizotomy would not be indicated per guideline recommendations. Furthermore, there are no updated physical examination findings consistent with positive facet signs such as pain with facet loading or tenderness directly over the L4-5 facets that would support the request. Given the lack of diagnostic medial branch blocks or an updated physical examination as previously identified by the prior reviewers, it is this reviewer's opinion that medical necessity for bilateral L4-5 rhizotomy is not established as the request does not meet guideline recommendations.

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)