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An Independent Review Organization

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Notice of Independent Review Decision

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Anesthesiology

Description of the service or services in dispute:

Lumbar facet rhizotomy L4/5, L5/S1 left side 1st day, right side 2nd day

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)

Patient Clinical History (Summary)

The patient is a male who was injured on xx/xx/xx. The patient has been followed for complaints of ongoing low back pain radiating to the lower extremities. The patient had been followed with complaints of low back pain, tingling, and muscle spasms. Pain ranged between 5 and 10/10 in intensity. The patient's treatment history did include multiple injections including sacroiliac joint injections performed in November of 2013. The patient also underwent facet blocks bilaterally in May of 2013. The patient is noted to have undergone prior lumbar rhizotomies, left and right at L4-5 and at L5-S1 in August of 2013. The patient reported 80% improvement following the radiofrequency rhizotomy procedures for approximately 1 week. By 09/09/13, the patient's pain had returned to 10/10 pain. The 03/16/15 clinical report noted that the previous radiofrequency procedures for the lumbar spine did provide significant improvement in terms of functional ability. The patient had recently fractured his lower extremity and had just had the cast removed. The patient's physical examination noted tenderness over the lumbar facet joints from L3 through S1. There was also tenderness over the sacroiliac joints. No focal neurological deficit was evident.

The proposed bilateral L4-5 and L5-S1 lumbar facet rhizotomy procedures were denied on 02/03/15 as there were findings consistent with lumbar radiculopathy.

The request was again denied on 02/26/15 as there was no clear rationale for the requested radiofrequency ablation procedures.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

In review of the clinical documentation submitted, the patient has had ongoing complaints of low back pain as well as sacroiliac joint pain with the most recent physical examination findings noting ongoing tenderness over the lumbar facets from L3 through S1 as well as tenderness over the sacroiliac joints. The previous radiofrequency ablation procedures for this patient were completed in August of 2013. Post-procedure reports noted significant pain relief; however, this was only for 1 week per the reports. Following the 1 week period, the patient's pain scores returned back to 10/10 pain. Given the lack of long term benefit obtained with the previous radiofrequency ablation procedures, guidelines would not support repeat procedures at this point in time. Guidelines recommend that there be at least 50% or more relief for 12 weeks to support repeat radiofrequency rhizotomy procedures at the same levels. As this is not clearly evident in the clinical documentation submitted for review, it is this reviewer's opinion that medical necessity for the proposed procedures would not be established at this point in time and the prior denials are upheld.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ACOEM-America College of Occupational and Environmental Medicine um
- knowledgebase AHCPH-Agency for Healthcare Research and Quality Guidelines
- DWC-Division of Workers Compensation Policies and
- Guidelines European Guidelines for Management of Chronic
- Low Back Pain Interqual Criteria
- Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- standards Mercy Center Consensus Conference Guidelines
- Milliman Care Guidelines
- ODG-Official Disability Guidelines and Treatment Guidelines

- Pressley Reed, the Medical Disability Advisor
- Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters
- Texas TACADA Guidelines
- TMF Screening Criteria Manual
- Peer Reviewed Nationally Accepted Médical Literature (Provide a description)

- Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)

