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Review Outcome

Description of the service or services in dispute:

Bilateral T12-L1 lumbar rhizotomy (64635 & 64636) under fluoroscopy (77003)

64635 - Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint
64636 – Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint

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

Board Certified Anesthesiology

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)

XX is a XX who was diagnosed with postlaminectomy syndrome, chronic pain syndrome, sacroiliitis and spondylosis without myelopathy or radiculopathy of the lumbar region. On XX, XX injured XX back when XX was walking towards XX desk, had a fall, and landed directly on XX back.

On XX, XX was evaluated by XX, DO for the chief complaint of lower back and hip pain. Per the note, XX had an epidural steroid injection in XX along with physical therapy and individual psychotherapy session in XX. On XX, XX had a left L4-L5 and L5-S1 transforaminal interbody fusion, posterior spinal fusion L4 through sacrum. In XX, XX had a posterior spinal fusion L2, L3 and L4 pedicle screw, XX placement with connectors to previous construct. XX had been placed on XX, XX patch and XX. XX had right and left L1-L2 lumbar facet rhizotomy on XX with 100% improvement. XX had right and left gluteus medius trigger point injections on XX with 50% improvement in myofascial related pain. XX had right and left T12-L1 lumbar medial branch posterior primary ramus block under fluoroscopy on XX with 85% improvement. XX ongoing pain centralized in the upper lumbar spine. On examination, XX weight was XX and body mass index was XX. Pain score was 8/10 while sitting and with activity, and 7/10 while standing. Lumbar spine was tender over the right and left T12-L1 facet. There was increased pain with lumbar extension. XX also had right and left sacroiliac joint tenderness. Patellar reflex was trace on the right and trace on the left. Achilles reflex was 1+ bilaterally.

A CT myelogram of the lumbar spine done on XX revealed extensive postoperative changes, posterior lumbar fusion L2 through S1, Harrington rods and transpedicular screws, laminectomies at L2-L3, L3-L4 and L4 through S1. At the L1-L2 level, there was a disc bulge, left lateral posterior osteophyte, posterior element hypertrophy, borderline thecal sac stenosis and modest left mild right inferior foraminal narrowing. At the L2-L3 level, there was posterior fusion, posterior osteophytes and facet hypertrophy that deformed the thecal sac, mild left anterolateral recess narrowing, and mild bilateral inferior foraminal narrowing. At the L3-L4 level, there was posterior fusion, laminectomy, posterior osteophytes and mild bilateral inferior foraminal narrowing. At the L4-L5 level, there was posterior fusion, laminectomy and posterior osteophytes. Posterior fusion, laminectomy and mild right foraminal narrowing were seen at L5-S1. Sacroiliac joints were intact

and mild degenerative sclerosis was seen. A CT scan of the thoracic spine done on XX, revealed mild posterior element hypertrophy from T9 through T11, causing mild thecal sac deformity.

Treatment to date consisted of medications (XX ,XX, XX multiple surgeries (left L4-L5 and L5-S1 transforaminal interbody fusion, posterior spinal fusion L4 through sacrum; posterior spinal fusion L2, L3 and L4 pedicle screw, Z-rod placement with connectors to previous construct) right and left L1-L2 lumbar facet rhizotomy with 100% improvement, right and left gluteus medius trigger point injections with 50% improvement in myofascial related pain, right and left T12-L1 lumbar medial branch posterior primary ramus block with 85% improvement, physical therapy, and individual psychotherapy.

Per a utilization review and accompanying physician advisor determination dated XX, the requested service of bilateral T12-L1 lumbar rhizotomy (64635, 64636) under fluoroscopy (77003) was noncertified by XX, MD (XX). Rationale: "Official Disability Guidelines discusses indications for lumbar rhizotomy. This treatment is noted to be under study with conflicting evidence as to the efficacy of this procedure. Approval of such treatment is recommended only on a case by case basis. This is a very complex case with multiple pain generators including a history of a lumbar fusion, as well as reported diagnoses of myofascial pain syndrome and sacroiliitis. Given these factors, as well as the notable chronicity of this injury dating back over a decade and a half, it does not appear that lumbar rhizotomy is likely to result in meaningful or meaningfully prolonged benefit to this patient. The patient's pain is generalized or at least notably regionalized with multiple pain generators, which have been present for an extended timeframe. In general, there is no evidence-based data to support the benefit of this procedure, particularly given the chronicity and complexity of this case, the treatment guidelines would not predict meaningful benefit from this treatment. Therefore, at this time, this request is not medically necessary and should be noncertified."

Per a utilization review and accompanying physician advisor determination dated XX, the prior denial for the requested service was upheld by XX, MD. The request for T12-L1 lumbar rhizotomy was deemed not medically necessary. The provider had lodged an appeal; however, no additional information had been submitted. Rationale: "After reviewing the case, there still remains uncertainty whether the pain is arising from the facet joints. The claimant has a history of lumbar fusion, myofascial pain syndrome, as well as sacroiliitis. Furthermore, evidence-based guidelines do not support this procedure strongly due to conflicting evidence. Overall, this request remains not medically necessary."

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

Two prior reviews conducted on XX and XX correctly identify the complexity of this case and the finding of multiple pain generators contributing to the composite pain presentation. The reviewers remain unconvinced that the proposed intervention will produce objective benefits.

My review finds that this position has ignored the findings of the previous intervention. In the provider report dated XX, it is noted that a L12 RFA performed in XX produced 100% pain relief. The note also states that a bilateral T12/L1 medial branch block performed on XX XX produced 85% relief. Details of the response are unfortunately sparse, such as what local anesthetic was used and what the duration of the relief was. However, a response of 85% pain reduction is a significant positive response. When the medial branch block was approved, the approval was probably dependent of an RFA procedure being performed if the MBB was positive – this is an ODG requirement. The provider further states that after the RFA, home exercise will be utilized which further complies with the ODG.

So, I find that the request for the bilateral T12/L1 RFA is reasonable and within the context and spirit of the OD. The requested services would be medically necessary and appropriate.

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

☐ AHRQ-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

Low Back - Lumbar and Thoracic (Acute and Chronic) (updated 05/04/18)

Facet joint intra-articular injections (therapeutic blocks)

Under study. Current evidence supporting this procedure is conflicting, and at this time, no more than one therapeutic intra-articular block is suggested. If this treatment is successful (pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive). If a therapeutic facet joint block is undertaken, it is suggested that it be used in concert with other evidence-based conservative care (activity, exercise, etc.) to facilitate functional improvement. (Dreyfuss, 2003) (Colorado, 2001) (Manchikanti, 2003) (Boswell, 2005)

See Facet joint diagnostic blocks (injections); Facet joint pain, signs & symptoms; Facet joint radiofrequency neurotomy; Facet joint medial branch blocks (therapeutic injections); and Segmental rigidity (diagnosis). See also the Neck Chapter and Pain Chapter.

Criteria for use of therapeutic intra-articular and medial branch blocks, are as follows:

1. No more than one therapeutic intra-articular block is recommended.

2. There should be no evidence of radicular pain, spinal stenosis, or previous fusion.

3. If successful (initial pain relief of 70%, plus pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive).

4. No more than 2 joint levels may be blocked at any one time.

5. There should be evidence of a formal plan of additional evidence-based activity and exercise in addition to facet joint injection therapy.

In spite of the overwhelming lack of evidence for the long-term effectiveness of intra-articular steroid facet joint injections, they remain a popular treatment modality. Intra-articular facet joint injections have been popularly utilized as a therapeutic procedure, but are not currently recommended as a treatment modality in most evidence-based reviews, as their benefit remains controversial. The therapeutic facet joint injections described here are injections of a steroid (combined with an anesthetic agent) into the facet joint under fluoroscopic guidance to provide temporary pain relief. (Dreyfuss, 2003) (Nelemans-Cochrane, 2000) (Carette, 1991) (Nelemans, 2001) (Slipman, 2003) (van Tulder, 2006) (Colorado, 2001) (ICSI, 2004) (Bogduk, 2005) (Resnick, 2005) (Airaksinen, 2006) An updated Cochrane review of injection therapies (ESIs, facets, trigger points) for low back pain concluded that there is no strong evidence for or against the use of any type of injection therapy, but it cannot be ruled out that specific subgroups of patients may respond to a specific type of injection therapy. (Staal-Cochrane, 2009)

Systematic reviews endorsing therapeutic intra-articular facet blocks:

Pain Physician, 2005: In 2005, there were two positive systematic reviews published in Pain Physician that stated that the evidence was moderate for short-term and limited for long-term improvement using this intervention. (Boswell, 2005) (Boswell, 2005) These results were based, in part, on five observational studies. These non-controlled studies were confounded by variables such as lack of confirmation of diagnosis by dual blocks and recording of subjective pain relief, or with measures that fell under verbal rating and/or pain relief labels (measures that have been reported to have problems with validity). (Edwards, 2005)

Pain Physician, 2007: Pain Physician again published a systematic review on this subject in 2007 and added one additional randomized trial comparing intra-articular injections with sodium hyaluronate to blocks with triamcinolone acetonide. The diagnosis of facet osteoarthritis was made radiographically. (Fuchs, 2005) Two randomized trials were not included, in part because they failed to include controlled diagnostic blocks. These latter articles were negative toward the use of therapeutic facet blocks. (Lilius, 1989) (Marks, 1992) An observational non-controlled study with positive results was included that made the diagnosis of lumbar facet syndrome based on clinical assessment of "pseudoradicular" lumbar pain, including evidence of an increase of pain in the morning and with excessive stress and exercise (no diagnostic blocks were performed). (Schulte, 2006) With the inclusion of these two articles, the conclusion was changed so that the evidence for lumbar intra-articular injections was "moderate" for both short- and long-term improvement of low back pain. (Boswell2, 2007)

Complications: These included suppression of the hypothalamic-pituitary-adrenal axis for up to 4 weeks due to steroids with resultant elevated glucose levels for less than a week. (Ward, 2002) There have been rare cases of infection (septic arthritis, epidural abscess and meningitis). (Cohen, 2007) Complications from needle placement include dural puncture, spinal cord trauma, intra-arterial and intravenous injection, spinal anesthesia, neural trauma, pneumothorax, and hematoma formation. (Boswell2, 2007)

Single photon emission computed tomography: (bone scintigraphy, SPECT scan): Not recommended, although recent research is promising. This technique is recommended based on the ability of radionuclide bone scintigraphy to detect areas of increased function, depicting synovial areas of inflammation as well as degenerative changes. Thirteen of 15 patients had a > 1 standard deviation pain score improvement at 1 month versus 7 of 32 patients with a negative or no scan. The benefit of the injection lasted for approximately 3 months and did not persist to 6 months. (Pneumaticos2, 2006)

Facet joint medial branch blocks (therapeutic injections)

Not recommended except as a diagnostic tool. Minimal evidence for treatment.

See also Facet joint intra-articular injections (therapeutic blocks).

Pain Physician 2005: In 2005, Pain Physician published an article that stated that there was moderate evidence for the use of lumbar medial branch blocks for the treatment of chronic lumbar spinal pain. (Boswell, 2005) This was supported by one study. (Manchikanti, 2001) Patients either received a local anesthetic or a local anesthetic with methyl prednisolone. All blocks included Sarapin. Sixty percent of the patients overall underwent seven or more procedures over the 2.5-year study period (8.4 ± 0.31 over 13 to 32 months). There were more procedures recorded for the group that received corticosteroids that those that did not (301 vs. 210, respectively). ["Moderate evidence" is a definition of the quality of evidence to support a treatment outcome according to Pain Physician.] The average relief per procedure was 11.9 ± 3.7 weeks.

Pain Physician 2007: This review included an additional randomized controlled trial. (Manchikanti2, 2007) Controlled blocks with local anesthetic were used for the diagnosis (80% reduction of pain required). Four study groups were assigned with 15 patients in each group: (1) bupivacaine only; (2) bupivacaine plus Sarapin; (3) bupivacaine plus steroid; and (4) bupivacaine, steroid and Sarapin. There was no placebo group. Doses of 1-2ml were utilized. The average number of treatments was 3.7 and there was no significant difference in number of procedures noted between the steroid and non-steroid group. Long-term improvement was only

thought to be possible with repeat interventions. All groups were significantly improved from baseline (a final Numeric Rating Scale score in a range from 3.5 to 3.9 for each group). Significant improvement occurred in the Oswestry score from baseline in all groups, but there was also no significant difference between the groups. There was no significant difference in opioid intake or employment status. There was no explanation posited of why there was no difference in results between the steroid and non-steroid groups. This study was considered positive for both short- and long-term relief, although, as noted, repeated injections were required for a long-term effect. Based on the inclusion of this study the overall conclusion was changed to suggest that the evidence for therapeutic medial branch blocks was moderate for both short- and long-term pain relief. (Boswell2, 2007)

Psychiatric comorbidity is associated with substantially diminished pain relief after a medial branch block injection performed with steroid at one-month follow-up. These findings illustrate the importance of assessing comorbid psychopathology as part of a spine care evaluation. (Wasan, 2009) The use of the blocks for diagnostic purposes is discussed in Facet joint diagnostic blocks (injections). The AHRQ comparative effectiveness study on injection therapies for LBP concluded that facet joint corticosteroid injections are not effective for presumed facet joint pain. (Chou, 2015)

Facet joint pain, signs & symptoms

Recommend diagnostic criteria below. It is recommended that a thorough patient history be obtained to exclude alternative etiologies of pain (particularly radiculopathies). Diagnostic blocks are required, as there are no findings on history, physical or imaging studies that consistently aid in making this diagnosis.

See also Facet joint diagnostic blocks (injections) and Segmental rigidity (diagnosis).

Suggested indicators of pain related to facet joint pathology (acknowledging the contradictory findings in current research):

(1) Tenderness to palpation in the paravertebral areas (over the facet region);

(2) Predominantly axial low back pain;

(3) Absence of radicular findings in a dermatomal distribution, although pain may radiate below the knee.

Controlled comparative blocks have been suggested due to the high false-positive rates (17% to 47% in the lumbar spine), but the use of this technique has not been shown to be cost-effective or to prevent a false-positive response to a facet neurotomy. (Bogduk, 2005) (Cohen 2007) (Bogduk, 2000) (Cohen2, 2007) (Mancchukonda 2007) (Dreyfuss 2000) (Manchikanti 2003) The most commonly involved lumbar joints are L4-5 and L5-S1. (Dreyfus, 2003) In the lumbar region, the majority of patients have involvement in no more than two levels. (Manchikanti, 2004)

Mechanism of injury: The cause of this condition is largely unknown, but suggested etiologies have included microtrauma, degenerative changes, and inflammation of the synovial capsule. The overwhelming majority of cases are thought to be the result of repetitive strain and/or low-grade trauma accumulated over the course of a lifetime. Less frequently, acute trauma is thought to be the mechanism, resulting in tearing of the joint capsule or stretching beyond physiologic limits. Osteoarthritis of the facet joints is commonly found in association with degenerative joint disease. (Cohen 2007)

Physical exam findings and symptoms: As most examinations simultaneously test several structures including muscles, ligaments, discs and facets, there is no suggested physical maneuver or tests to effectively diagnose facet joint mediated pain. Axial low back pain is generally present with lumbar paravertebral tenderness. There is no reliable pain referral pattern other than that pain is “pseudoradicular.” It is suggested that pain from upper facet joints tends to extend to the flank, hip and upper lateral thighs, while the lower joint mediated pain tends to penetrate deeper into the thigh (generally lateral and posterior). Infrequently, pain may radiate into the lateral leg or even more rarely into the foot, although multiple references indicate pain distal to the knee is rarely associated with facet joint pathology. In the presence of osteophytes, synovial cysts (diagnosed with MRI) or facet hypertrophy (diagnosed on imaging), radiculopathy may also be present. In patients with these latter conditions, injection therapy will generally not alleviate pain that originates primarily from the anterior or posterior ligaments or bone. (Cohen 2007) (van Kleef, 2010)

(Schulte, 2006) (Tessitore, 2014) (Cohen, 2013) (Wilde, 1988) In 1998, Revel et al. suggested that the presence of the following were helpful in identifying patients with this condition: (1) age > 65; (2) pain relieved when supine; (3) no increase in pain with coughing, hyperextension, forward flexion, rising from flexion or extension/rotation. (Revel, 1998) Recent research has corroborated that pain on extension and/or rotation (facet loading) is a predictor of poor results from neurotomy, but in general, previous and subsequent studies have failed to corroborate these findings. (Cohen2, 2007) The condition has been described as both acute and chronic. (Resnick, 2005)

Radiographic findings: There is no support in the literature for the routine use of imaging studies to diagnose lumbar facet mediated pain. Studies have been conflicting in regards to CT and/or MRI evidence of lumbar facet disease and response to diagnostic blocks or neurotomy. (Cohen 2007) Degenerative changes in facets identified by CT do not correlate with pain and are part of the natural degenerative process. (Kalichman, 2008)

Differential diagnosis: Other causes of predominantly axial low back pain must be considered in the differential diagnosis including discogenic pain, sacroiliac joint pathology, ligamentous injury, and myofascial pain. Within the context of facet pathology, inflammatory arthritis should be considered as a differential diagnosis. Conditions include rheumatoid arthritis, ankylosing spondylitis, gout, psoriatic arthritis, reactive arthritis (and other spondyloarthropathies) as well as osteoarthritis and synovitis.

Facet joint radiofrequency neurotomy

Under study. Conflicting evidence is available as to the efficacy of this procedure, and approval of treatment should be made on a case-by-case basis (only 3 RCTs with one suggesting pain benefit without functional gains, potential benefit if used to reduce narcotics).

See Facet joint diagnostic blocks (injections); Facet joint pain, signs & symptoms; Facet joint medial branch blocks (therapeutic injections); and Facet joint intra-articular injections (therapeutic blocks). See also the Neck Chapter and Pain Chapter.

Criteria for use of facet joint radiofrequency neurotomy:

(1) Treatment requires a diagnosis of facet joint pain using a medial branch block as described above. See Facet joint diagnostic blocks (injections).

(2) While repeat neurotomies may be required, they should not occur at an interval of less than 6 months from the first procedure. A neurotomy should not be repeated unless duration of relief from the first procedure is documented for at least 12 weeks at ≥ 50% relief. The current literature does not support that the procedure is successful without sustained pain relief (generally of at least 6 months duration). No more than 3 procedures should be performed over the course of a year.

(3) Approval of repeat neurotomies depends on variables such as evidence of adequate diagnostic blocks, documented improvement in VAS score, decreased medications and documented improvement in function.

(4) No more than two joint levels are to be performed at one time.

(5) If different regions require neural blockade, these should be performed at intervals of no sooner than one week, and preferably 2 weeks for most blocks.

(6) There should be evidence of a formal plan of additional evidence-based conservative care in addition to facet joint therapy.

Studies have not demonstrated improved function. Also called Facet rhizotomy, Radiofrequency medial branch neurotomy, or Radiofrequency ablation (RFA), this is a type of injection procedure in which a heat lesion is created on specific nerves to interrupt pain signals to the brain, with a medial branch neurotomy affecting the nerves carrying pain from the facet joints.

Current research: Multiple placebo-controlled trials have been completed on this topic, but these studies all had potential clinical methodologic flaws including the use of non-controlled diagnostic blocks and potential discrepancies in technique of lesioning from that which is currently recommended. (Hooten, 2005) (van Kleef, 1999) (Boswell, 2005) (Leclaire, 2001) (Van Kleef, 1999) (Gallagher, 1994) (van Wijk, 2005) A recent small RCT found that the percutaneous radiofrequency neurotomy treatment group

showed statistically significant improvement not only in back and leg pain but also back and hip movement as well as the sacroiliac joint test. There was significant improvement in quality of life variables, global perception of improvement, and generalized pain. But RF neurotomy was not a total treatment, and it provided relief for only one component of the patients' pain. (Nath, 2008) Observational Trials: One observational trial found 60% of patients received 90% relief at 12 months and 87% had 60% pain relief. The authors used confirmatory blocks with 80% pain relief. (Dreyfuss, 2000) Clinical audits have reported pain relief in almost 70% of patients at 6 months. (Gofeld, 2007) Among the top 5 tests and therapies that are of questionable usefulness in the field of pain medicine, as prepared by the American Society of Anesthesiologists (ASA) and the American Pain Society (APS) is to avoid irreversible interventions for noncancer pain, such as peripheral chemical neurolytic blocks or peripheral radiofrequency ablation, because such interventions may be costly and carry significant long-term risks of weakness, numbness, or increased pain. (ASA, 2014)

Systematic reviews: When compiled into systematic reviews, the evidence has been found to be conflicting for a short-term effect (Niemisto-Cochrane, 2003) (Niemisto-Cochrane, 2006) and moderate to strong for a long-term effect when compared to a placebo. (Geurts, 2001) (Boswell, 2005) The latter systematic review failed to distinguish results between lumbar and cervical patients. A critical nonsystematic review by Slipman et al. reported “sparse evidence” to support use in the lumbar region (Slipman, 2003) and the ICSI did not feel the current scientific evidence allowed for a conclusion on the subject. (ICSI, 2005) Boswell et al. have recently published a systematic review that included several new observational studies that came to the conclusion that the evidence for neurotomy was moderate (Level III) for long-term relief of cervical and lumbar facet joint pain. This conclusion was based on the standard techniques used in the United States. (Boswell2, 2007) Interventional strategies, such as prolotherapy, botulinum toxin injections, radiofrequency denervation, and intradiscal electrothermal therapy, are not supported by convincing, consistent evidence of benefit from randomized trials. (Chou, 2008)

Technique: There are several techniques. (Gofeld2, 2007) The North American technique uses tangential insertion of a curve-tipped cannula parallel to the nerves. There is a long learning curve and results vary among operators. The European technique relies on radiologic appearance. Potential technical flaws include inadequate exposure of the tip to the target nerve and generation of a lesion that is too small to ablate the nerve. There is also an Australian technique.

Factors associated with failed treatment: These include increased pain with hyperextension and axial rotation (facet loading), longer duration of pain and disability, significant opioid dependence, and history of back surgery.

Factors associated with success: Pain above the knee (upper leg or groin); paraspinal tenderness. (Cohen2, 2007)

Duration of pain relief: One retrospective analysis has determined that the mean duration of relief is approximately 10-12 months (range 4-19 months). Subsequent procedures may not be as successful (possibly secondary to technical failure or progression of spinal degeneration). (Schofferman, 2004) In a more recent study 68.4% of patients reported good to excellent pain relief at 6 months and showed consistent results with the above findings. (Gofeld, 2007)

Complications: Potential side effects include painful cutaneous dysesthesias, increased pain due to neuritis or neurogenic inflammation, and cutaneous hyperesthesia. Neuritis is the most frequent complication (5% incidence). (Boswell, 2005) (Boswell2, 2007) (Cohen, 2007) The clinician must be aware of the risk of developing a deafferentation centralized pain syndrome as a complication of this and other neuroablative procedures. This procedure is commonly used to provide a window of pain relief allowing for participation in active therapy. (Washington, 2005) (Manchikanti, 2003)

- ☐ Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters
- ☐ Texas TACADA Guidelines

Case Number: XXXX Date of Notice: 07/10/18

☐ TMF Screening Criteria Manual

☐ Peer Reviewed Nationally Accepted Medical Literature (Provide a description)

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

Appeal Information

You have the right to appeal this IRO decision by requesting a Texas Department of Insurance, Division of Workers' Compensation (Division) Contested Case Hearing (CCH). A Division CCH can be requested by filing a written appeal with the Division's Chief Clerk no later than 20 days after the date the IRO decision is sent to the appealing party and must be filed in the form and manner required by the Division.

Request for or a Division CCH must be in writing and sent to:
Chief Clerk of Proceedings Texas Department of Insurance
Division of Workers' Compensation P. O. Box 17787
Austin, Texas, 78744

For questions regarding the appeals process, please contact the Chief Clerk of Proceedings at 512-804-4075 or 512- 804-4010. You may also contact the Division Field Office nearest you at 1-800-252-7031.