Specialty Independent Review Organization

Notice of Independent Review Decision

Date notice sent to all parties: 12/11/2017

IRO CASE #: XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
The item in dispute is the prospective medical necessity of right lumbar rhizotomy L3, L4, and L5.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The reviewer is a Medical Doctor who is board certified in 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)

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a XXXX who was injured on XXXX, in a mechanism that was not denoted. The claimant was diagnosed with chronic pain syndrome and lumbago. An evaluation on XXXX, revealed that the claimant was having continued pain in the lower back rated as 4/10 on a Visual Analog Scale. Current medications included topical diclofenac, hydrocodone, and topical lidocaine. The physical examination of the lumbosacral spine revealed tenderness to palpation of the right lumbar facet at L3-S1 and there was positive facet rocking and range of motion was decreased by 20%. There was no evidence of radiculopathy in the bilateral lower extremities.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The claimant has continued pain in the lower back. According to the guidelines, facet joint radiofrequency neurotomy is not recommended as there is a lack of evidence to support the efficacy of this procedure. The guidelines state that approval should be made on a case-by-case basis. There is no evidence of previous conservative treatment and diagnostic imaging made available for review to support the request. The request for right lumbar rhizotomy L3, L4, and L5 is not medically necessary.

Official Disability Guidelines –TWC ODG Treatment Integrated Treatment/Disability Duration Low Back (Acute and Chronic) (updated 08/02/17) ODG guidelines Facet joint radio frequency 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). 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.

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

☐ **ACOEM- AMERICAN 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)**