True Resolutions Inc.
An Independent Review Organization
1301 E. Debbie Ln. Ste. 102 #624
Mansfield, TX 76063
Phone: (512) 501-3856
Fax: (888) 415-9586
Email: manager@trueresolutionsiro.com

IRO REVIEWER REPORT

Date: 1/22/2018 3:55:22 PM CST

IRO CASE #: XXXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Radiofrquency Thermocoagulation (RFTC) Rhizotomy Lumbar Left L3, L3, L4 under anesthesia with Fluoro Guidance

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

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☐ Overturned	Disagree
☐ Partially Overturned	Agree in part/Disagree in part
☒ Upheld	Agree

PATIENT CLINICAL HISTORY [SUMMARY]:

This case involves a now XX-year-old XXXX with a history of an occupational claim from XXXXX. The mechanism of injury is detailed as occurring when the patient XXXXX. The current diagnoses are documented as CRPS to the lower limb and lumbar displacement. Prior relevant treatment included medications, physical therapy, injections, elevation, orthotic shoes, ice/heat, fracture boot, immobilization and use of compression. Relevant medications included clonazepam, hydrocodone, Motrin, promethazine, Butrans and hydrocodone/acetaminophen. On XXXXX, the patient was seen for evaluation regarding complaints of the left lower extremity pain due to complex regional pain syndrome. The patient reportedly underwent a diagnostic left lumbar sympathetic block which resulted in 2 full days of 100% pain relief. The physical examination findings included no deformity or tenderness in the back. There was edema in the left leg with intact peripheral pulses. The treatment plan included radiofrequency thermocoagulation rhizotomy of the lumbar spine on the left at L2, L3 and L4. The request for radiofrequency thermocoagulation rhizotomy of the lumbar spine was previously denied as the documented diagnosis of CRPS 2 of the lower limb and lumbar disc displacement was not an approved indication for the requested procedure.

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

According to the Official Disability Guidelines, radiofrequency neurotomy is under study due to conflicting evidence of efficacy. The criteria of the procedure include a diagnosis of facet joint pain with medial branch block and evidence of a formal plan of additional evidence-based conservative care in addition to facet joint therapy. Per the submitted documentation, the patient reportedly underwent a diagnostic left lumbar sympathetic block which resulted in 2 full days of 100% pain relief. There was no evidence of radicular findings on examination. However, there was a lack of documentation including a plan for additional evidence-based conservative care in addition to facet joint therapy as indicated by the evidence based guidelines.

As such, the previous denial is upheld and the request for Radiofrequency Thermocoagulation (RFTC) Rhizotomy Lumbar Left L2, L3, L4 under anesthesia with Fluoro Guidance is not medically necessary.

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

☐ AHRQ- 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 JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TEXAS TACADA GUIDELINES

☐ TMF SCREENING CRITERIA MANUAL

Official Disability Guidelines (ODG), Treatment Index, 14th Edition (web), 2016, Low Back, Facet joint radiofrequency neurotomy