Independent Resolutions Inc.

An Independent Review Organization
835 E. Lamar Blvd. #394
Arlington, TX 76011
Fax: 817-549-0310

Notice of Independent Review Decision

DATE OF REVIEW: 12/17/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Radiofrequency thermocoagulation bilaterally at L3 through S1 facet joints.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
M.D., neurologist, fellowship trained pain specialist, board certified in Neurology and Pain Medicine

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
1. Adverse Determination Report from dated 11/12/07 and 11/28/07
2. Office notes by Dr. dated 11/15/07 and 11/07/07
3. MRI report of the lumbar spine without contrast dated 05/07/07
4. ODG Guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:
This claimant sustained a work-related injury on xx/xx/xx with resultant pain primary axial in the lumbar spine and bilateral with some radiation into the midback and upper back. No radicular symptoms are evident in the office notes reviewed. The claimant underwent bilateral median nerve blocks of the facet joints at L3/L4, L4/L5, and L5/S1 on 10/23/07 with followup office notes indicating that he reported significant relief of his pain by at least 50% for the day of the block. Because of this response, a radiofrequency thermocoagulation procedure targeting the same levels was requested.

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

This claimant has had a significant response to the median branch facet blocks that were completed, presumably purely for diagnostic clarification and not necessarily for any therapeutic benefit. (It is unclear to this reviewer if any steroid was used, but this would be unlikely since these injections were targeting the median branches and not the facet joints themselves.) Because of the positive response to the diagnostic blocks, this claimant indeed would be an excellent candidate for the next logistical step, which would be treatment with a radiofrequency denervation of the same median branch nerves at the same levels that were blocked. This will presumably be followed by an appropriate physical therapy and exercise program, as well.

Previous reviewers have indicated an "absolutely normal MRI" and "no objective findings" to suggest facet-mediated pain, as well as the fact that the facet blocks provided 50% relief "for only one day." The Reviewer finds these reasons for adverse determination to be inadequate, as facet joint pain would not necessarily except to show any abnormalities on imaging such as MRI scan, and the response to the facet blocks, indeed, can be taken as objective evidence for facet-mediated pain, as is the case in this claimant, and the facet blocks if done purely for diagnostic purposes would not be expected to result in any sustained pain relief beyond a few hours. Once diagnostically confirmed, as was the case, more sustained relief is then hoped for with the radiofrequency procedure that has been requested.

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)**