

# IRO America Inc.

An Independent Review Organization  
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DATE OF REVIEW:

JULY 20, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right radiofrequency thermocoagulation at L4-5 S1

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

MD Board Certified Orthopedic Surgeon

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

MRI lumbar spine 09/21/06  
Procedure note 11/22/06, 12/12/06  
Progress note of, PA-C 01/19/07, 04/20/07  
Office note of Dr. 05/15/07, 05/24/07, 05/31/07  
Peer review 05/31/07, 06/14/07  
IRO Request 07/10/07 and 07/12/07  
Patient Pain Update  
Request for medial branch block, 05/04/07 and 05/24/07  
Request for RFTC 05/25/07, 06/05/07 and 06/06/07

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male injured on xx/xx/xx in an unknown manner. He has been treated for low back and leg pain. A 09/21/06 MRI of the lumbar spine showed an L4-5 far left lateral annular tear with no neural compression or displacement and the posterior joints were normal. L5-S1 was normal.

On 01/19/07 Dr. documented that the claimant had pain at 8/10. He had numbness in the legs as well as low back and right leg pain. Medications were Lyrica and Hydrocodone. On examination there was an antalgic gait. No spasm or paravertebral tenderness was appreciated. The claimant was tender over the left, lower lumbar facets. Straight leg raise on the right caused back and right leg pain. The impression was chronic back pain into lower extremities, facet pain and depression. The same findings were noted on the 04/20/07 examination although. It was also noted that the claimant had 40-60 percent relief with epidural steroid injection. Pain was 40 percent legs and 60 percent back. Medications were continued and medial branch blocks recommended.

The claimant underwent right medial branch block at L4-S1 on 05/15/07. Pain prior to the injection was 5 and after 0-1. On 05/24/07 right medial branch block was again provided at L4-S1 with pain 4 before and 0 after. Radiofrequency thermocoagulation has now been requested and denied on two previous peer reviews. An appeal has issued for the same request.

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

The Reviewer agrees with the carrier in this case.

This is a male with low back and leg pain since xx/xx/xx. He has symptoms of numbness of the legs with positive straight leg raise causing some question of a radicular component. There is no facet pathology on the MRI. In general the Official Disability Guidelines do not recommend facet ablation procedures as there is a lack of long term studies that show improved function with this procedure and often the procedure must be repeated and as such there is a lack of long term efficacy in terms of pain control. Official Disability Guidelines also recommend that when this treatment is considered that no more than two levels be addressed. The request for right radiofrequency thermocoagulation at L4, 5 and S1 cannot be recommended.

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  
Official disability Guidelines Treatment in Worker's Comp 2007 Updates, Low Back-Facet Radiofrequency Neurotomy:
  - 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)