

# Independent Resolutions Inc.

An Independent Review Organization

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**DATE OF REVIEW:** 09/30/07

**IRO CASE #:**

## **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Left radiofrequency thermocoagulation (RFTC) of lumbar facets from L3 to S1

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

Neurologist and 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. Preauthorization decision and rationale, dated 08/08/07
2. Preauthorization decision and rationale, dated 08/29/07
3. Progress notes from Center from 05/14/07, 06/04/07, 08/01/07, 09/05/07
4. Procedure note, dated 06/15/07, for right-sided RFTC at L3-4, L4-5, and L5-S1
5. Description of disputed issue by, dated 09/20/07 (three pages, completed by Dr.)
6. Report for MRI of the lumbar spine, dated 07/26/05
7. Letter by Dr., dated 08/21/07, requesting approval for repeat left RFTC procedure in the lumbar facet joints
8. ODG Guidelines

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

This claimant, sustained a work-related injury on xx/xx/xx, resulting in low back pain and lower extremity pain. This claimant noted onset of pain while answering some telephones and faxes, while working as receptionist and during some twisting motions. Diagnostic studies have included x-rays of the lumbar spine, at least two MRIs of the lumbar spine, and EMG-NCV studies of the lower extremities. Imaging studies reportedly showed only minimal degenerative disc changes, but without evidence for nerve root impingement or spinal stenosis. A report for the repeat lumbar MRI is available, dated 07/26/05, and is interpreted as showing some hypertrophy of the ligamentum flavum on the left at L4-5, and a disc bulge at L5-S1, more toward the right. Some disc degeneration is noted at the L4-5 and L5-S1 levels. Part of the first page of this MRI report is cut off and is not readable by this reviewer. I am not able to find results of the EMG-NCV studies. Treatment attempts have included opioid pain relievers (such as sustained-release morphine), chiropractic treatments, physical therapy, injections (including epidural steroid injections and facet joint injections), and radiofrequency procedures to the facet joints on both sides. A radiofrequency procedure was completed on the left lumbar facet joints on 06/04/07 and the right side was then completed on 06/15/07. Notes indicate that pain on the right side remains improved, though the left-sided improvement lasted for a few weeks. The pain then returned, prompting the request for a repeat radiofrequency procedure on the left-sided facet joints. A note by Dr. from 08/01/07 indicates that the claimant reports that her pain is “not as severe” on the left side as it was initially, but had clearly increased again after the improvements she had seen immediately after the radiofrequency procedure was completed on that side.

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

The Reviewer essentially agrees with prior reviewers that a repeat radiofrequency thermocoagulation is not indicated, as there is no evidence to suggest that a repeat procedure will offer any greater or prolonged relief of symptoms. It should be noted that the claimant continues to have radicular pain, which would not be expected to benefit from a radiofrequency procedure targeting the facet joints.

**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)