



Notice of Independent Review Decision

**DATE OF REVIEW:** 4/28/08

**IRO CASE #:**

**NAME:**

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

Determine the appropriateness of the previously denied request for radiofrequency ablation (RFA), left-sided lumbar medical nerve branch and physical medicine, 1 session.

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

Texas licensed Anesthesiologist.

**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.

The previously denied request for radiofrequency ablation (RFA), left-sided lumbar medical nerve branch and physical medicine, 1 session.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

- Nurse UM Summary dated 4/22/08.
- Utilization Review Findings dated 4/4/08, 3/15/08.
- Follow-Up Note dated 2/28/08, 8/3/07, 7/19/07, 2/1/07, 4/18/06, 2/14/06.
- Procedure Report dated 1/25/07, 4/11/06, 2/7/06.
- Imaging Report dated 7/5/05.
- Facet Injections Instructions (unspecified date).
- Provider Information (unspecified date).

**PATIENT CLINICAL HISTORY (SUMMARY):**

**Age:** xxyears

**Gender:** Male

**Date of Injury:** xx/xx/xx

**Mechanism of Injury:** Not provided for review.

**Diagnosis:** Lumbago.

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

The claimant is a xx-year-old male who sustained a work-related injury on xx/xx/xx. The mechanism of injury was not documented. The current diagnosis appears to be lumbago. Current medication management consists of Norco, Soma, Baclofen, Ambien and Ultram. Pertaining to the patient's lumbar spine, there was no available clinical information in support of the disputed interventional pain management injection; particularly no physical/objective finding submitted or any other information pertaining to patient's low back pain. Therefore, without the above information and lack of medical necessity determined by the requesting provider, it is opinion of this reviewer that the denial for RFA left-sided lumbar medial branch nerves and physical medicine, one session be upheld. It is also noted that ACOEM Guidelines do not recommend lumbar radiofrequency ablations secondary to lack of proven efficacy. In reference to one session physical medicine. it is assumed that this refers to physical therapy. Justification for this is absent in the reviewed documents, a home exercise program would normally suffice for patients with this diagnosis. Likewise, ODG states, "Conflicting evidence is available as to the efficacy of this procedure...Studies have not demonstrated improved function."

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

X ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE.

ACOEM Guidelines, 2<sup>nd</sup> Edition, Chapter 12.

- 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.

**X ODG – OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES.**

Official Disability Guidelines, Treatment Index, 5<sup>th</sup> Edition, 2008 – Low Back-Diagnostic Facet Blocks – Intraarticular Facet Blocks.

- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND PRACTICE PARAMETERS.
- TEXAS TACADA GUIDELINES.
- TMF SCREENING CRITERIA MANUAL.
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION).

**X OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION).**  
Practice Guidelines, 1<sup>st</sup> Edition, 2004, Spinal Diagnostic and Treatment Procedures (ISIS), Edited by N. Bogduk, M.D.