

SENT VIA EMAIL OR FAX ON  
Dec/19/2008

## Pure Resolutions Inc.

An Independent Review Organization  
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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**  
Dec/12/2008

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**  
Bilateral lumbar radiofrequency ablation L5/S1

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

M.D., Board Certified in pain management and anesthesiology under the American Board of Anesthesiologists.

**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)

**PATIENT CLINICAL HISTORY SUMMARY**

Per the office visit note dated 09/26/08, the patient complains of low back pain. On that same note, it is noted that the patient received a "left LMBB" on 09/12/08. The procedure note dated 09/12/08 states that a "left lumbar medial branch block under fluoroscopy L1, L2, L3, L4, L5, S1" was performed. Per the office visit noted dated 09/26/08, the "procedure did help relieve some of his pain for about one day." There is nothing listed as to how much pain relief the patient received or if there was any increase in function. The request, however, is for a bilateral lumbar radiofrequency ablation L5/S1.

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

Per the Official Disability Guidelines, a radiofrequency nerve ablation should not be performed unless there has been a diagnostic block performed. It is noted that the request is for a bilateral lumbar radiofrequency ablation. Per the procedure note date 09/12/08, only a left-sided lumbar medial branch block was performed. It was also performed at multiple levels. Therefore, the request is not appropriate at this time given that 1) there was not a right-sided medial branch block performed, and 2) it is difficult to tell if the L5-S1 facet joint is the cause of the pain given that multiple levels were performed on the same day. Therefore,

at this time, this request is not appropriate.

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

ACOEM-AMERICA 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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

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