



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION Workers' Compensation Health Care Non-network (WC)

01/30/2008

DATE OF REVIEW: 01/30/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left L2, L3, & L4 lumbar sympathetic radiofrequency

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

Texas State Licensed MD Board Certified Anesthesiology & Pain Management physician

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

1. Texas Dept of Insurance Assignment to 01/10/2008
2. Notice to URA of assignment of IRO dated 01/10/2008
3. Confirmation of Receipt of a Request for a Review by an IRO 01/09/2008
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 01/07/2008
6. Utilization Review 01/02/2008 & 11/29/2007
7. Face Sheet 01/07/2008
8. Office notes 12/04/2007; 11/26/2007 (Pre Auth & Appeal); 07/11/2007; 07/20/2007; 05/29/2007; 04/30/2007; 03/28/2007
9. Screen prints Dr. 11/27/2007; 11/28/2007; 11/29/2007; 12/20/2007; 12/31/2007
10. ODG guidelines were not provided by the URA



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PATIENT CLINICAL HISTORY:

This is a xx year-old female, who sustained a work-related injury involving the left leg and foot secondary to when a desk drawer pulled out and fell striking the above left lower extremity. The work-related injury occurred on xx/xx/xx. Subsequent to the accident, the patient's condition continued to worsen and a diagnosis of left lower extremity chronic regional pain syndrome (CRPS) was provided by a Dr., M.D. (pain management physician). Following this, the patient underwent left lumbar sympathetic nerve blocks performed on 10/12/2006 and 11/06/2006 with reportedly not much relief from the injections. After this, it appears that the patient underwent a left lumbar sympathetic post-radiofrequency (PRF) on 11/28/2006 and a repeat procedure in March of 2007. It appears that patient had initially 30 to 40 percent improvement following the first radiofrequency ablation procedure of which was short-lived and reportedly 70 percent relief following the second procedure of which patient continued to complain of muscle spasms to the left leg/foot, tingling sensations to the toes/left foot, and a return of burning pain to the left foot thereafter.

Current medications include Neurontin 300 mg two PO TID, Norco 10/325 mg half to one PO Q4H, Skelaxin 800 mg one PO TID and Zyrtec.

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

Of note, from the documentation submitted, there is no reporting of any physical modalities prior to and status post interventional pain management procedures. On the information provided, it appears that claimant has exhausted multiple efforts at obtaining lumbar sympathetic radiofrequency procedures.

ODG Guidelines do not recommend sympathectomy. A more invasive recommended treatment is the usage of neurostimulation with spinal cord stimulator.

In conclusion, the above-requested procedure had been denied secondary to: 1) Lack of efficacy with the prior similar procedures in percentage of pain relief, increased functioning, and decreased medication intake; 2) It is not recommended by ODG Guidelines.

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 KNOWLEDGBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES



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- 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)**