



Notice of Independent Review Decision

DATE OF REVIEW: 7/30/08

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for bilateral L2-S1 radiofrequency thermocoagulation (RFTC).

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

Texas licensed 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.

The previously denied request for bilateral L2-S1 RFTC.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Fax cover sheet/notes dated 7/17/08.
- Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 7/11/08.
- Company Request for IRO dated 7/11/08.
- Fax cover sheet dated 7/17/08.
- Notice of Denial of Pre-Authorization dated 6/5/08, 6/4/08.
- Notice of Reconsideration dated 6/19/08.
- Fax cover sheet/notes dated 5/28/08.
- Request for a Review by an Independent Review Organization dated 6/26/08.
- Determination letter dated 6/19/08.
- Log Note dated 7/1/08.
- S.O.A.P. notes dated 5/22/08, 10/4/06, 9/13/05.
- Fax/notes dated 7/17/08.
- Notice of Assignment of Independent Review Organization dated 7/14/08.
- Pre-Authorization Request, First Request dated 5/22/08.
- Physician Review/General dictation report dated 6/17/08, 6/3/08.
No guidelines were provided by the URA for this referral.

PATIENT CLINICAL HISTORY (SUMMARY):

Age: xx years

Gender: Female

Date of Injury: xx/xx/xx

Mechanism of Injury: Pulling a washer weighing 500 pounds.

Diagnosis: Lumbar spondyloarthritis, sacroiliac pain, radicular syndrome.

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

The patient is a xx-year-old female who sustained an injury, on xx/xx/xx, when she was pulling a washer with an estimated weight of 500 pounds. The diagnoses included lumbar spondyloarthritis, sacroiliac pain, radicular syndrome. The patient had a lumbar facet block, on August 30, 2005, which provided 100% relief for 2-3 days and she subsequently underwent radiofrequency thermocoagulation (RFTC) that was extremely beneficial. On October 4, 2006, the patient was re-evaluated noting she had excellent results from the September 2005 radiofrequency thermocoagulation and the patient was then experiencing the same pain again and again, an RFTC was performed.

The report by , dated, July 1, 2008, documented the patient's subjective complaints of bilateral lumbar pain radiating to the right buttock, and midway down the right thigh. The last RFTC was performed approximately one year earlier, and was from L2 to S1 bilaterally. The stated procedure yielded 80% relief of her symptoms until recently. A report by Dr. dated May 2, 2008, documented physical examination findings of a positive Kemp's test. On that date, the patient reported that the RFTC had afforded good consistent relief previously, but the pain had returned. The Official Disability Guidelines, Treatment Index, 6th Edition (web), 2007 set out criteria for use of facet joint radiofrequency neurotomy which include, but are not limited to, the following: "...While repeat neurotomies may be required, they should not occur at an interval of less than 6 months from the first procedure. A neurotomy should not be repeated unless duration of relief from the first procedure is documented for at least 12 weeks at \geq 50% relief..." In this case the patient was afforded an 80% relief of her symptomatology for a period that was somewhat ambiguous, however, this reviewer has drawn the inference that the symptomatic relief was slightly less than one year. Based thereon, the bilateral L2-S1 radiofrequency thermocoagulation (RFTC) in question would be supported by the Official Disability Guidelines. Accordingly, the previously denied request for bilateral L2-S1 radiofrequency thermocoagulation (RFTC) should be overturned.

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

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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 (ODG), Treatment Index, 6th Edition (web), 2008, Low back—
Facet rhizotomy.

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).

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

