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Notice of Independent Review Decision

Date of Review: 06-06-08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Radiofrequency Thermocoagulation at right L4-S1 under fluroscopy

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

Certified by The American Board of Anesthesiology
Anesthesiology - General
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)

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Upheld/ Overturned
		Prospective	724.3	64622	Upheld

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INFORMATION PROVIDED TO THE IRO FOR REVIEW

Notice of Determination dated 04-22-08 and 05-14-08
Pre-authorization request form dated 04-17-08
Request for reconsideration dated 05-08-08
Initial Evaluation dated 04-12-07
Opinion Report dated 03-14-06, 12-29-06, 11-13-07
Medical progress notes dated 09-09-05, 09-13-05, 09-28-05, 10-12-05, 11-02-05,
11-14-05, 12-05-05, 12-19-05, 01-24-06, 02-28-06, 03-21-06, 04-11-06,
04-25-06, 05-16-06, 05-30-06, 06-21-06, 06-27-06, 08-01-06, 08-15-06,
09-12-06, 09-26-06, 10-10-06, 10-31-06, 11-13-06, 11-27-06, 01-11-07,
01-25-07, 02-15-07, 03-15-07, 04-06-07, 04-26-07, 05-15-07, 06-05-07,
06-29-07, 07-10-07, 07-31-07, 08-13-07, 08-27-07, 09-11-07, 10-03-07,
10-15-07, 11-08-07, 11-19-07, 12-13-07, 01-17-08, 01-31-08, 01-31-08,
02-14-08, 03-04-08, and 04-17-08
Letter of Medical Necessity dated 02-26-08
Follow-up Note dated 12-13-05 (follow-up visit on 08-10-07)
Initial Evaluation dated 04-12-07
Initial Rehab Assessment 10-03-05
Rehabilitation (physical therapy) record dated 10-21-05, 10-24-05, 10-28-05,
10-31-05, 11-02-05, 11-04-05, 11-07-05, 11-09-05, 11-11-05, 11-14-05,
11-18-05, 11-22-05, 11-28-05, 11-30-05, 12-02-05 (re-evaluation), 02-23-06,
02-24-06, 02-27-06, 02-28-06, 03-01-06, 03-02-06, 03-03-06, 03-08-06,
03-09-06, and 03-10-06,
DME Prescription 10-11-06
Nerve Conduction Study (NCS) dated 11-21-05
Nerve Conduction and Electromyography Study dated 12-22-05
ERGOS Evaluation Summary Report dated 01-27-06
Functional Capacity Evaluation report dated 03-17-06, 02-27-07
Behavioral Health Evaluation dated 08-17-07 & 09-19-07
Review of Medical History and Physical Exam dated 03-20-06
Initial Consultation Note dated 11-15-05 (follow-up notes: 03-30-06, 05-10-06,
05-31-06, 07-05-06, 07-11-06, 07-26-06, 08-30-06, 10-11-06, 11-08-06,
11-29-06, 12-2-06, 01-10-07, 02-12-07, 05-23-07, and 07-11-07)
Initial Orthopedic Evaluation dated 12-12-06
Designated Doctor Reports dated 04-26-06, 09-22-06, 08-22-07
Operative Notes dated 04-04-06, 04-18-06, 06-30-06, 08-04-06, 11-17-06,
12-15-06, 01-05-07
MRI left knee dated 09-20-05
MRI lumbar spine dated 11-07-05
Emergency record of 09-12-05

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Texas Workers' Compensation Work Status Reports
Subsequent Medical Report dated 02-26-08
Letter of 05-22-08
Official Disability Guidelines (ODG) – 2008, Internet, Low Back Chapter, Facet joint radiofrequency neurotomy – Criteria for use of facet joint radiofrequency neurotomy

PATIENT CLINICAL HISTORY:

This is a xx-year-old claimant with chronic back pain since the injury of xx/xx/xx, when the claimant slipped and fell from a ladder to the ground. Since injury, the claimant has had chronic and severe pain to the low back, which is constant. The treatment has included pain management, multiple facet injections with significant relief. The claimant was referred for radiofrequency thermocoagulation of the facet joints. The claimant has had functional capacity evaluations and maximum medical improvement (MMI) evaluations. The claimant denies previous chiropractic therapy, acupuncture, or massage therapy.

The recommendation of treating provider for lumbar facet nerve root ablation treatment was denied as not medically necessary for this claimant.

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

The Physician Reviewer reviewed the ODG Guidelines and supports the denial of the requested procedure, "radiofrequency thermocoagulation right L4-S1 levels."

According to the Reviewer, the claimant's physical examination findings and radiologic evidence is consistent with the diagnosis of lumbar facet syndrome. However, the Reviewer noted that there is no evidence the claimant has undergone any diagnostic lumbar medial branch blocks to verify the source of the claimant's pain.

Per the ODG Guidelines:

Criteria for use of facet joint radiofrequency neurotomy include, but are not limited to:

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1. Treatment requires a diagnosis of facet joint pain using a medial branch block as described above. See Facet joint diagnostic blocks (injections).
2. There should be evidence of a formal plan of additional evidence-based conservative care in addition to facet joint therapy.

From the provided medical data, the claimant has undergone the following procedures:

1. 04-04-06: "two level lumbar facet diagnostic block at the L4, L5, and S1 levels"; insufficient information exists to clarify if these were facet joint injections or medial branch blocks
2. 05-14-06: "underwent a second set of facet injections"; 50% benefit
3. 06-03-06: "the physician performed lumbar facet joint injections on the right"
4. 08-04-06: "left sided facet joint injection was performed"

In the evaluation of 09-22-06, the claimant "noted that the previous bilateral lumbar facet blocks had provided 60% relief for about 3 weeks."

The claimant then underwent a series of three lumbar epidural steroid injections with moderate relief from the first two and no benefit from the third injection.

In conclusion, in the opinion of the Reviewer, the requested procedure is not medically necessary for the claimant at this time.

**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)