



COMPARTNERS



Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 5/28/08

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

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

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

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 RFTC.

There were no guidelines provided by the URA for this referral.

PATIENT CLINICAL HISTORY (SUMMARY):

Age: xx years
Gender: Male
Date of Injury: xx/xx/xx
Mechanism of Injury: Not provided for review.

Diagnosis: Lumbar radiculopathy and chronic low back pain.

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

The claimant's is a xx-year-old male who sustained a work-related injury on xx/xx/xx, involving the lumbar spine. The mechanism of injury was not provided. Of note, this injury is almost six years old. The current diagnoses appeared to be lumbar radiculopathy and chronic low back pain. This claimant was treated in the past with lumbar RFTC at levels L3 through S1, performed on xx/xx/xx. Of note, there was no post injection documented response to the previously performed procedure. At that time, the claimant complained of deep aching pain in the low back and buttock region, accompanied by some weakness and tenderness in the lumbar region. In addition, the claimant was also suffering from left lower extremity radiculopathy. The current medication management appears to consist of Darvocet and Vicoprofen. In addition, there was no radiographic imaging studies' report submitted with this review. After review of the information submitted, the previously non-authorization for bilateral lumbar medial branch nerve thermocoagulation at levels L3 to S1 is upheld. There was no documented objective finding indicating this claimant is specifically suffering from lumbar facet joint pain. It appeared that following the previously performed bilateral radiofrequency ablation procedure, there was no documentation indicating at least 50% pain relief for at least 12 weeks. In addition, it appears that the claimant is suffering from lumbar radiculopathy, for which the requested intervention would not be appropriate. Therefore, due to lack of documentation to determine the medical necessity for the repeat radiofrequency thermocoagulation procedure and in accordance with ODG, the recommendation is to uphold the previous adverse determination.

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.

X ODG – OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES.

Official Disability Guidelines, 2008 (Web), Integrated Treatment, Back-Disability Duration, Neck and Upper Back (acute and chronic)--Facet joint radiofrequency neurotomy.

□ 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).