

# I-Resolutions Inc.

An Independent Review Organization  
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**DATE OF REVIEW:**

May/04/2009

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Thermal Radiofrequency ablation L4-S1 Bilateral facet joints (64622, 64623, 77003)

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

M.D., board certified in Orthopedic Surgery

**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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

ODG Guidelines

Adverse Determination Letters, 4/6/09, 4/13/09

MD, 3/30/09

Facet Nerve Block(s), 3/16/09

MD, Chart Note, 2/13/09

MD, Chart Note, 2/9/09

MD, Chart Note, 1/12/09, 11/14/08, 10/20/08, 8/18/08

Lumbar Myelogram with Post Myelogram CT of the Lumbar Spine, 2/2/09

ESI, 12/8/08

Operative Report, 1/14/05

Lumbar Discogram, 7/28/04

CT Lumbar Spine w/contrast, 7/28/04

Lumbar ESI (L3-L4, L4-L5), 4/29/04

Lumbar ESI, 6/3/04

MRI of Lumbar Spine, 1/14/04, 5/8/03, 5/01

Interpretive Report, 2/18/03

#### **PATIENT CLINICAL HISTORY SUMMARY**

This patient was injured on xx-xx-xx. The patient has had an L5/S1 anterior interbody fusion with BAKK subsequently being determined to be solid. She had medial branch blocks on 03/16/09, which apparently gave her good relief, with the pain returning one through eight days afterwards with a 50% improvement. She has documentation of radiculopathy and has had imaging studies, which showed mild facet arthropathy at L5/S1, which is a fused level with no open facet, and minimal facet arthropathy at L4/L5. Current request is for facet manipulation with ablation with radiofrequency neurotomy.

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

This procedure does not conform to the ODG. The treating provider has not provided an explanation for why the Guidelines should not be followed. The ODG criteria states that blocks such as these in patients with radiculopathy or previous fusion is not recommended. Without satisfactory explanation from the requestor as to why the guidelines should be set aside in this particular case, this reviewer has no way of knowing the thought process of that provider based on the medical records submitted. It is for this reason that the requested procedure could not be approved. The reviewer finds that medical necessity does not exist for Thermal Radiofrequency ablation L4-S1 Bilateral facet joints (64622, 64623, 77003).

#### **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 REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)