



Notice of Independent Review Decision

IRO REVIEWER REPORT – WC NETWORK

DATE OF REVIEW: 07/26/10

DATE OF AMENDMENT: 07/27/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Radio Frequency Ablation at Bilateral L3-S1 with Fluoroscopic Guidance

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

Board Certified in Pain Management and Rehabilitation

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.

Radio Frequency Ablation at Bilateral L3-S1 with Fluoroscopic Guidance - UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

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PATIENT CLINICAL HISTORY (SUMMARY):

The records available for review document that the date of injury was listed as xx/xx/xx. On the date of injury, the patient was stretching the low back region by leaning over to touch her toes, and she developed difficulty with low back pain. She was evaluated at on xxxxxx and diagnosed with a lumbar strain. She received at least eight sessions of supervised therapy services from 06/08/09 to 07/02/09. An electrodiagnostic assessment of the lower extremities was accomplished on 06/17/09 which disclosed findings consistent with a left S1 radiculopathy. The patient underwent a mental health evaluation on 06/23/09, which noted previous treatment included “individual psychotherapy, medication, and physical therapy.” It was recommended that she undergo ten sessions of treatment in an interdisciplinary pain management program. A sacrum MRI scan was obtained on 12/14/09 which revealed no abnormalities of the sacrum to be present. The lumbar spine and sacral x-rays were accomplished on 12/14/09 which revealed findings consistent with possible narrowing of the L5-S1 disc space. The patient was then evaluated by Dr. Dent on 01/11/09 and it was documented there was a positive straight leg raise test in the left lower extremity. It was recommended that the patient receive access to treatment in the form of a transforaminal epidural steroid injection (ESI), which was later performed. She then received at least eight sessions of supervised therapy services from 02/01/10 to 05/20/10. The patient was evaluated by Dr. on 03/23/10 and it was noted that a lumbar MRI scan was accomplished on 12/14/09, which revealed “some signal change in the discs at L4-L5 and L5-S1.” There were no findings worrisome for a compressive lesion upon any of the neural elements in the lumbar spine. On 04/01/10 the claimant was evaluated by Dr. and it was documented there was a positive straight leg raise test in the left lower extremity. It was recommended that the patient receive access to treatment in the form of physical therapy services. On 04/20/10 she underwent a right and left L4-L5 and L5-S1 median branch block. A Peer Review was accomplished on 05/04/10 which indicated the treatment in the form of diagnostic facet blocks did not appear to be indicated as there were radicular symptoms noted to be present. On 05/13/10 Dr. Dent re-evaluated the claimant and documented that there was a positive straight leg raise test at 45 degrees in the left lower extremity. It was recommended that the patient receive access to treatment in the form of facet joint radiofrequency neurotomy procedure. A Designated Doctor Evaluation (DDE) was conducted on 05/24/1 and the patient was placed at Maximum Medical Improvement. The patient was diagnosed with a lumbar sprain which had resolved and also with “chronic lumbar pain.” She was awarded a total body impairment of 0%. A Functional Capacity Evaluation (FCE) disclosed that the claimant appeared capable of light duty work activities.

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

Based upon the medical records available for review, treatment in the form of a bilateral radiofrequency ablation procedure at the bilateral L3 to S1 level with fluoroscopic guidance would not appear to be of medical necessity per criteria set forth by the Official

Disability Guidelines.

The above-noted reference does not support a medical necessity for treatment in the form of facet joint injections when there is documentation of radicular pain. An electrodiagnostic assessment on 06/17/09 revealed findings consistent with a left S1 radiculopathy. Additionally, the records available for review document on multiple occasions that there were findings on physical examination consistent with a lumbar radiculopathy.

Additionally, the described mechanism of injury would not be considered to be a mechanism of injury that would result in trauma to the lumbar facet joints. It is documented that the patient was in a flexed posture with respect to the lumbar region when an injury was sustained in the workplace. This described mechanism of injury would not generally be expected to result in a pain syndrome referable to the lumbar facet joints.

Official Disability Guidelines also indicate that the requested procedure is “under study.” It is documented that there is conflicting evidence in the medical literature as it relates to long-term benefit from the requested procedure.

Consequently per criteria set forth by the Official Disability Guidelines, the requested procedure would not be considered to be of medical necessity for the described medical situation.

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)**