

- Notice of IRO to CompPartners, Inc. of Case Assignment dated 9/30/10.
- Receipt of a Request for a Review by an Independent Review Organization dated 9/29/10, 9/28/10.
- Company Request for IRO dated 9/29/10.
- Physician Advisor Report dated 9/22/10, 9/2/10.
- Letter of Appeal dated 9/15/10.
- There were no guidelines provided by the URA for this referral.

PATIENT CLINICAL HISTORY (SUMMARY):

Age: xx

Gender: Male

Date of Injury: xx/xx/xx

Mechanism of Injury: He slipped and fell while cleaning tubs.

Diagnosis: Chronic low back pain, status post lumbar fusion L4 through S1 performed in 1999 with additional subsequent surgeries in 2000, 2003, and 2004.

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

This male sustained a work-related injury on xx/xx/xx involving the lumbar spine. The mechanism of injury occurred when the claimant slipped and fell while cleaning tubs. Subsequent to the injury, the claimant had a working diagnosis of chronic low back pain, status post lumbar fusion L4 through S1 performed in 1999 with additional subsequent surgeries in 2000, 2003, and 2004. Reportedly, the claimant underwent lumbar spinal cord stimulator placement in 2006. A note submitted indicated this patient has undergone multiple sets of radiofrequency thermocoagulation lesioning in the past. The most recent was performed on 1/14/10 where the radiofrequency ablation was performed on the right levels at T12 through S1. Following this procedure, this claimant subjectively reported 65% improvement in back pain, but notes indicated current medication profile to include Avinza 60mg a day being consistently prescribed. Currently, the patient was complaining of low back pain and weakness in the left lower extremity with numbness/heaviness. Objective findings revealed decreased sensation in the right L4 and L5/left S2 dermatomal distributions; reflexes of lower extremities were absent bilaterally; straight leg raise was positive bilaterally; Patrick's and Fabere's Test was positive bilaterally. Medication profile consisted of Avinza 30mg twice a day, Clonazepam, Remeron, Cymbalta, and Norco 10/325mg. Of note, this claimant has also had multiple trigger point injections in the lumbar spine. It was also noted that in July 2010, the claimant underwent a left knee arthroscopy and was currently awaiting for a right knee arthroscopy to be performed. Medical records review performed by M.D., contained the opinion that under chronic pain treatment further injections were not recommended as it appeared that this claimant tended to receive as much benefit from acupuncture as from any injection provided by Dr.. This could indicate actual response and/or possibly placebo response. After review of the information submitted, the previous non-authorization of the requested intervention has been upheld. The

ODG states, "Criteria for use of facet joint radiofrequency neurotomy: (2) 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 >50% relief. The current literature does not support that the procedure is successful without sustained pain relief (generally of at least 6 months duration). No more than 3 procedures should be performed in a year's period. (3) Approval of repeat neurotomies depends on variables such as evidence of adequate diagnostic blocks, documented improvement in VAS score, and documented improvement in function. (4) No more than two joint levels are to be performed at one time." This patient's subjective improvement following the procedure performed in January is questionable and suspect. There appeared to be no decrease in opioid medication usage from the notes submitted. In addition, there was no documentation of improved function following the procedure. There was no evidence of a formal plan of rehabilitation in addition to the facet joint therapy submitted. No more than two levels are to be performed at one time. Therefore, in accordance with Official Disability Guidelines, the recommendation is to uphold the previous non-authorization of the request for radiofrequency injections at right T12, L1, L2, L3, L4, L5, and S1 (CPT codes 64622, 64623, 99144, 77003).

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.
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).