

SENT VIA EMAIL OR FAX ON
Apr/01/2011

Independent Resolutions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Apr/01/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient Right S1, S2, S3 lateral branch radiofrequency thermocoagulation

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

Board Certified Anesthesiologist/Pain Management

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

OD Guidelines

1. Cover sheet and working documents
2. Notice of utilization review findings dated 03/14/11, 02/25/11
3. Notice of intent to issue an adverse determination dated 03/11/11, 02/24/11
4. Medical records Dr.
5. Procedure report dated 09/14/10, 10/06/09, 06/25/09
6. EMG/NCV dated 04/16/09
7. Left hip CT scan dated 12/09/08
8. MRI lumbar spine dated 10/16/03, 09/20/02, 12/06/1999
9. CT discogram dated 02/20/01
10. Medical records Dr.

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male whose date of injury is xx/xx/xx. CT discogram of the lumbar spine dated 02/20/2001 revealed central annular tear or disc herniation at L4-5. MRI of the lumbar

spine dated 10/16/03 revealed persistent moderately severe stenosis on the right at L5-S1 to the subarticular and posterolateral disc protrusion; unchanged degenerative disc disease at L4-5. Left hip CT scan dated 12/09/08 revealed no evidence of acute change; lumbar spondylosis and lumbar facet arthropathy. EMG/NCV dated 04/16/09 indicates that the patient has never had surgery but has had multiple injections. The study is reported as normal.

Note dated 01/05/09 indicates that the patient's problems are likely coming from the SI joint and the patient was recommended for sacroiliac joint injection. Note dated 03/04/09 indicates that the patient is having quite a bit of radiculopathy. The patient underwent bilateral L5-S1 transforaminal epidural steroid injection on 06/25/09. Follow up note dated 08/12/09 indicates that the patient reports 70% improvement. The patient underwent bilateral L4-5 transforaminal epidural steroid injection on 10/06/09. Follow up note dated 11/05/09 indicates that the patient reports the last injection gave him some relief of his pain but not much. This note indicates that Dr. opines that the patient's pain may be related to the sacroiliac joints and the inflammation in the nerves in this area may be causing the heavy feeling in the patient's lower extremities. Serial records indicate that impression is lower back pain syndrome, lumbar radiculopathy, SI joint pain and chronic intractable pain syndrome.

The patient underwent bilateral sacroiliac joint injection on 09/14/2010. Follow up note dated 01/25/11 indicates that the SI joint arthrogram helped at least 75%, and he is very eager to continue with another. On physical examination flexion and extension of the lumbar spine produce pain. He also has pain to the SI joints with palpation. Straight leg raising, Slump's test and Kemp's test are negative. Physical examination on 01/26/11 reports positive Stork, Faber's and pelvic compression test.

Initial request for outpatient right S1, S2, S3 lateral branch radiofrequency thermocoagulation was non-certified on 02/24/11 noting that ODG recommends repeat blocks if the diagnostic block is successful instead of radiofrequency ablation. The denial was upheld on appeal on 03/11/11 noting that ODG and ACOEM do not discuss this issue. In reviewing the literature, it appears that this procedure is relatively new and the criteria for its use is poorly described and understood. Therefore, selecting appropriate cases is difficult, and generally ODG does not support experimental procedures.

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

Based on the clinical information provided, the request for outpatient right S1, S2, S3 lateral branch radiofrequency thermocoagulation is not recommended as medically necessary, and the two previous denials are upheld. The patient underwent sacroiliac joint injection on 09/14/2010 and reported at least 75% relief. The Official Disability Guidelines report that in the treatment or therapeutic phase (after the stabilization is completed), the suggested frequency for repeat blocks is 2 months or longer between each injection, provided that at least >70% pain relief is obtained for 6 weeks. There is no provision regarding lateral branch radiofrequency thermocoagulation. As stated by the previous reviewer, this procedure is relatively new and the criteria for its use is poorly described and understood. The Official Disability Guidelines do not generally support experimental procedures, and as such the request is not indicated as medically necessary, and the two previous denials are upheld.

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)