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Notice of Independent Review Decision

DATE OF REVIEW: NOVEMBER 14, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed radiofrequency ablation right L4, right L5 and S1 under fluoroscopy

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Physical Medicine and Rehabilitation and is engaged in the full time practice of medicine.

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)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
unk	radiofrequency ablation right L4, right L5 and S1 under fluoroscopy		Prosp	1					Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

The medical records presented for review begin with a non-certification of the above listed request. It was noted that the clinical findings do not support the medical necessity for this treatment. Specifically, there were no objective findings that would cause concern for facet joint mediated pain.

The request was submitted for reconsideration. This reconsideration noted that the claimant had undergone lumbar surgical intervention at L5/S1. There does not appear to be any significant relief of the symptomology associated with this intervention. The requesting provider sought ablation of the right L4, L5 and S1 nerve roots. This was not endorsed as there was limited efficacy of the median branch block completed.

The medical record from the requesting provider begins with an October 7, 2011 note from believes that the determination made by the reviewing provider was "false". The provider took exception to the fact that there was no pain associated with facet loading as a reason to not certify the request. It was outlined on September 22, 2011, that there was tenderness over the mid to lower lumbar region, more so on the right, straight leg raises elicited back pain only, and the neurologic examination was intact.

The September 22, 2011 orthopedic report noted back and bilateral shoulder injuries dating back to xx/xx/xx. It was also identified that there was a medial branch block performed on September 12, 2011, and that there was significant, although temporary, relief. The back pain is rated as 8/10 and noted to be constant. The physical examination is as outlined above.

The August 22, 2011 progress note focused on the bilateral shoulders and that the second post operative visit from the revision of the right shoulder arthroscopy that had been completed. The physical therapy to the shoulders had been performed and some relief is noted. It was noted that there was mechanical axial back pain.

The prior progress notes all reflect the shoulder surgery and changes. It is also noted that a Designated Doctor evaluation had been completed and that maximum medical improvement had not been reached.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

RATIONALE:

As noted in the Division mandated Official Disability Guidelines, facet joint radiofrequency neurotomy is "understudy" thus, the efficacy of this procedure has not been thoroughly

objectified. The facet joint medial branch block is not recommended except as a diagnostic tool. In this case there was some relief albeit for a very temporary period. Therefore, there is no clear clinical indication of any efficacy associated with this type of procedure.

The second issue is that as per the criteria for facet joint radiofrequency neurotomy (4), no more than two joint levels are to be performed at one time. There is some confusion as to the request as one place indicated that the L4, L5 and S1 nerve roots were to be treated and another note indicated the L4/L5 and L5/S1 levels. This confusion does not support the request.

Therefore, overall, there is insufficient clinical data presented to support this request. There is significant doubt as to the efficacy of such an injection and overall this type of intervention has not been established as the prevailing standard of care. Consequently, the non-certification is upheld.

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
- XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- XX 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)