



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION Workers' Compensation Health Care Non-network (WC)

Date: December 19, 2011

DATE OF REVIEW: 12/19/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Is the bilateral pulse ablation, L4-L5, deemed medically necessary for this patient?

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

Review of this appeal was conducted by a clinical peer reviewer Board Certified in the area of Anesthesiology/Pain Management. This physician is a Diplomate of the American Academy of Pain Management and is licensed to practice in California, New Jersey, New York, and Texas. He received his MD at the Mount Sinai School of Medicine of New York University with residency in Anesthesiology at the Long Island College Hospital. Additionally, he has professional society memberships with American Society of Anesthesiologists, Society for Education on Anesthesia, and the International Anesthesia Research Society. This physician has a specialist in treating pain. This physician has been a Pain Management Specialist for over a decade and has extensive experience in treatment of painful disorders, including headaches, and various pain management regimens.

REVIEW OUTCOME [PROVIDE FOR EACH HEALTH CARE SERVICE IN DISPUTE]

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.



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INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Texas Dept of Insurance Assignment to Medwork 12/01/2011
2. Notice of assignment to URA 11/30/2011
3. Confirmation of Receipt of a Request for a Review by an IRO 12/01/2011
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 11/30/2011
6. Non-Authorization form 11/28/2011, pre-certification request 11/17/2011, letter from medical doctor 11/17/2011, Insurance information 11/15/2011, pre-certification request 11/15/2011, medicals 11/09/2011, 10/25/2011, pre-certification request 09/28/2011, medicals 09/14/2011, pre-certification request 08/16/2011, medicals 07/20/2011, 06/29/2011, insurance information 06/21/2011, follow-up evaluation 06/21/2011, follow-up evaluation 11/18/2010, medicals 11/16/2010, 11/03/2010, 10/20/2010, 09/09/2010, 09/07/2010, 08/04/2010, 05/18/2010, 04/12/2010, 04/08/2010, 02/23/2010, 12/11/2007, 12/04/2007, 06/11/2007, 05/24/2007, 05/08/2007, 04/26/2007, 04/21/2007, 04/18/2007, other medical information.
7. ODG guidelines were not provided by the URA

PATIENT CLINICAL HISTORY:

The patient is a female and has a history of low back pain that radiates into the legs. The patient when seen for an exam has stated tenderness with decreased range of motion and a positive Hoffman sign. She is status post lumbar surgery so therefore has a diagnosis of failed back syndrome. The patient has had selective nerve root blocks with good relief. MRI shows disk bulge at L4-L5 and L3-L4. She is on Elavil, Soma, Lidoderm, Vicodin, Cymbalta, and Zanaflex.

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

When referring to the *Official Disability Guidelines'* chapter on low back pain under facet joint diagnostic blocks, it does state that there is recommendation for one set of medial branch blocks prior to a facet neurotomy if facet neurotomy is chosen as an option for treatment. It also states that the use of a confirmatory block has been strongly recommended due to the high rate of false-positives with a single block. The patient has not had a medial branch block yet, so therefore the procedure is not deemed medically necessary.

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 KNOWLEDGBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES



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- 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)