



Southwestern Forensic
Associates, Inc.

DATE OF REVIEW: 06/05/12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient injection bilateral L4-L5, L5-S1 radiofrequency neurotomy

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., Board Certified in Anesthesiology by the American Board of Anesthesiology with Certificate of Added Qualifications in Pain Management, in practice of Pain Management full time since 1993

REVIEW OUTCOME:

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

ODG are met for the requested procedure.

INFORMATION PROVIDED FOR REVIEW:

1. Non-certification information, 1/27/11, 3/8/12
2. Clinical notes, Dr. 11/18/11 thru 2/22/12
3. TDI referral information
4. Operative report, Dr. 1/13/12
5. Notes from 10/31/11 thru 11/8/11
6. Appeals for reconsideration, 3/21/12, 4/19/12

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

This individual sustained a work-related injury on xx/xx/xx when he was carrying a stretcher with a 400-pound patient, the stretcher dropped, and he reached to assist the patient. Conservative therapy has been performed including anti-inflammatory medication, pain medications, six sessions of physical therapy, and an ongoing home

exercise program. Median branch block performed on 01/13/12 resulted in temporary relief.

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

Previous reviewers denied the radiofrequency neurotomy based on the ODG requirement for rehabilitation efforts. The reviewers stated there were no evidence-supported Rehabilitation efforts in place. Dr. describes that this individual has had physical therapy, a trial of medications and is compliant with a home exercise program. No other rehab measures are consistent with ODG. The current rehab efforts are sufficient to satisfy ODG and to approve the procedure.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR DECISION:

(Check any of the following that were used in the course of your review.)

- 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 judgment, 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)