



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION WORKERS' COMPENSATION - WC

January 10, 2013

DATE OF REVIEW: 01/07/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Bilateral facet RFTC at levels L4 through S1.

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

Texas State Licensed MD Board Certified Anesthesiology & Pain Management Physician

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)

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Texas Dept of Insurance Assignment to Medwork 12/21/2012
2. Notice of assignment to URA 12/20/2012
3. Confirmation of Receipt of a Request for a Review by an IRO 12/21/2012
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 12/21/2012
6. Letter from insurance plan 12/24/2012, 12/20/2012, peer review report 12/18/2012, letter from insurance plan 11/09/2012, peer review report 11/07/2012, letter from patient's physician 11/01/2012, patient notes from physician 10/17/2012, initial evaluation of patient 10/17/2012, review notes of patient 06/14/2012.

PATIENT CLINICAL HISTORY:

The patient is a male who sustained a work-related injury, involving the right scapula, low back, and neck. Documentation submitted indicates the patient underwent multiple invasive procedures involving the lumbar spine performed by treating physician, which include epidurals, facet blocks, and RFTC procedures. According to RME (required medical evaluation) physician, none of these procedures have led to any lasting objective or functional improvement in the



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patient's condition involving the lumbar spine. Of note, the RME examination did not correlate with the clinical examination submitted on October 17, 2012. Additional notes indicate a chronic pain management program was completed in 2010. Of note, entrance into the chronic pain management program is predicated on the fact that no additional surgical interventions or injections are likely to help this patient. Additionally, prior to consideration of CPMP, all diagnostic testing and procedures should have been performed. Reported lumbar MRIs performed in 2009 and 2010 revealed disk bulges at L4-L5 and L5-S1 levels, with degenerative changes noted. The patient has subjective complaints of low back pain. From the extensive and thorough clinical examination performed, there is no evidence of lumbar radiculopathy, no treatable abnormalities of the lumbar spine. The patient essentially had age-appropriate degenerative changes noted.

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

The patient does not appear, based on the information available to the reviewer, to have a reasonable suspicion for lumbar facet joint pain. There is no examination showing lumbar facet joints as the pain generator, according to the examinations. The reported lumbar MRI showed no facet hypertrophy or other facet problems. This patient has non-correlating objective clinical examinations. There is no documentation that the previous individual pain management injections have led to any lasting effect on this patient's improvement in decreasing pain and/or function.

Therefore, in accordance with *Official Disability Guidelines* (low back chapter) criteria for use of facet joint radiofrequency neurotomy, the previous denial of bilateral facet RFTC at levels L4 through S1 has been upheld.

Treatment requires a diagnosis of facet joint pain using a medial branch block, as described above.

1. No more than two joint levels are to be performed at one time.
2. Limited to patients with low back pain that is non-radicular and at no more than 2 levels bilaterally.

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
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN



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- 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)**