

# US Decisions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Feb/22/2010

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Outpt Lumbar Rhizotomy, fluoroscopy + hardware 64622 64623 77003 64999

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

M.D., Board Certified in Pain Management and Anesthesiology by the American Board of Anesthesiologists

**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**

ODG Guidelines and Treatment Guidelines  
Adverse Determination Letters, 1/11/10, 1/27/10  
Anesthesiology, P.A., 1/21/10, 12/7/09, 9/17/09, 8/20/09  
10/19/09, 12/7/09  
Medical Center, 7/26/05

**PATIENT CLINICAL HISTORY SUMMARY**

This patient is post lumbar fusion L5-S1. The operative report was not provided. The patient received a diagnostic medial branch block (L3-4 and L4-5) with only local anesthetic on 10/19/09. The patient had "almost 100% pain reduction" although the duration of this relief is not documented beyond the first 72 hours. The last specific description of the patient's pain was on 9/17/09. It was described as "lumbar neuraxial pain down the left hip and left leg." On 1/21/10, her pain was described only as 8/10, with sitting producing a 7 to 8/10 pain score, standing and activity producing an 8/10 pain score. A physical exam has not been performed since 9/17/09. There is no mention of the patient's "hardware" in the notes provided.

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

Given that the patient's current pain location and physical exam has not been updated for 5 months, the records are unclear as to whether the patient is currently having facet joint pain.

ODG requires that facet joint pain be verified through history and physical exam. In addition to this, the ODG requires evidence of a formal plan of additional evidence-based conservative care in addition to facet joint therapy. This formal plan was not provided in the materials presented for this review. The records are also unclear as to the request regarding the patient's hardware. The reviewer finds that medical necessity does not exist at this time for Outpt Lumbar Rhizotomy, fluoroscopy + hardware 64622 64623 77003 64999.

**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)