

# Clear Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Jan/20/2012

**IRO CASE #:**

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

O/P Lumbar Radiofrequency Ablation L5-S1 outpatient

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

M.D., Board Certified Anesthesiology/Pain Management

**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**

Official Disability Guidelines

Utilization review findings 11/04/11

Utilization review findings 11/30/11

Insurance Company response regarding disputed services 01/05/12

CT lumbar spine 10/08/10

CT cervical spine 10/08/10

Orthopedic reports Dr. 11/22/10 through 10/28/11

Designated doctor evaluation Dr. 01/26/11

Post designated doctor required medical examination Dr. 06/07/11

Operative report lumbar medial branch block 09/20/11

Medical report and post injection physical therapy evaluation Dr. 09/21/11, 10/19/11 and 12/19/11

Physical therapy notes 10/07/11 and 10/12/11

Statement pharmacy services 08/15/11 through 12/19/11

Request for causation letter law office 03/24/11

Request for medical contested case or SOA hearing 01/31/11

Notice of independent review decision 01/28/11 regarding denial LESI L5-S1

Electromyographic examination 01/25/11

CT arthrogram 01/11/11 right shoulder

Right shoulder x-ray two views 01/11/11

Manual muscle testing and range of motion 03/28/11

Utilization review referral 11/01/11

Pre-authorization reconsideration request 11/21/11

IRO determination 05/18/11 regarding right lumbar medial branch blocks

Operative report right shoulder arthroscopy 06/22/11

Pre-authorization review determination 05/20/11, 04/27/11, 04/15/11, 11/30/10, and 12/03/10

#### **PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a male whose date of injury is xx/xx/xx. He sustained injuries to his neck, lower back and right shoulder in a motor vehicle accident. He had physical therapy and oral anti-inflammatories with temporary relief. He underwent right shoulder arthroscopy on 06/22/11 with subacromial decompression, repair of SLAP tear, and rotator cuff repair. A request for right lumbar medial branch blocks was denied, but denial was overturned on IRO dated 05/18/11. Lumbar medial branch blocks were performed on the right at L4-5 and L5-S1 on 09/20/11. Dr. medical reports indicated the claimant reported mild increasing back pain since injection and states pain referred to his right leg and groin region. Per Dr. orthopedic report dated 10/28/11 the claimant noticed significant relief following the injection. Dr. recommended proceeding with radiofrequency ablation.

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

This man is noted to have sustained multiple injuries secondary to motor vehicle accident on xx/xx/xx. A diagnostic medial branch block was performed on 09/20/11. Subsequent medical reports from Dr. noted that the claimant reported mild increase in back pain since injection, but Dr. reported the claimant experienced significant relief. The extent of relief was not quantified nor was duration of relief. Per ODG guidelines, there should be response of at least 70% pain relief. Given lack of documentation indicating the claimant had appropriate response of at least 70% pain relief following injection, the reviewer finds medical necessity is not established for the proposed O/P Lumbar Radiofrequency Ablation L5-S1 outpatient.

#### **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)