US Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/02/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: radiofrequency neurolysis ablation, L5-S1 bilaterally

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O., Board Certified Physical Medicine and Rehabilitation and Pain Medicine

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. It is the opinion of this reviewer that the request for a radiofrequency neurolysis ablation, L5-S1 bilaterally is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
ODG - Official Disability Guidelines & Treatment Guidelines
Clinical notes dated 11/12/12 – 06/20/13
Operative report dated 05/08/12
MRI of the lumbar spine dated 11/26/12
Peer review dated 01/25/13
Previous utilization reviews dated 06/13/13 & 07/08/13

PATIENT CLINICAL HISTORY [SUMMARY]: The documentation mentions the patient being a male who is noted to have a low back injury from an incident on xx/xx/xx. The patient is noted to have undergone a laminectomy at L4-5 on 05/08/12. A completed MRI of the lumbar spine on 11/26/12 revealed no gross abnormalities at L5-S1. According to the clinical note on 11/12/12 signed the patient had low back complaints with numbness and tingling on occasion in both legs. Numbness was noted in the left leg when walking about 2 miles and the patient gets tingling in both legs on occasion. Pain was also described as a burning, shooting, and aching sensation that was moderate in intensity. The clinical note dated 02/19/13 details the patient having previously undergone an epidural steroid injection which did provide 6 days of benefit with a 10% relief of pain with a gradual return. The patient rated the pain as 6/10 at that time. The clinical note signed on 04/02/13 mentions the patient having completed 6 physical therapy sessions to date. Bilateral lumbar pain with numbness was noted upon exam. The clinical note from 06/05/13 details the patient reporting 90% reduction in pain from the previous lumbar facet block. The clinical note on 06/11/13 revealed the patient continuing with complaints of numbness and weakness in the left leg. The patient also reported a shooting type pain from the low back that was rated as 6/10.

The previous utilization review dated 06/13/13 for a radiofrequency ablation at L5-S1 bilaterally resulted in a denial secondary to the patient complaining of a radiculopathy component in the lower extremities with radiating pain.

The previous utilization review dated 07/08/13 for a radiofrequency ablation resulted in a denial secondary to the patient having a history of complaints of low back pain with radiating pain to the lower extremities.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The clinical notes mention the patient having complaints of pain localized to the lumbosacral junction with 10% of the pain noted to be radiating to the left leg. Additionally, decreased sensation is noted in the left L5 dermatome. A radiofrequency ablation would be indicated for this patient if the patient is noted to have no significant radiating pain from the low back. Given the significant clinical findings indicating the patient having specific complaints of pain into the left lower extremity, this request is not indicated as medically necessary. As such, it is the opinion of this reviewer that the request for a radiofrequency neurolysis ablation, L5-S1 bilaterally is not recommended as medically necessary.

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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)