

US Resolutions Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/15/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: left L5-S1, S1, S2, S3 RFTC

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Anesthesiology and 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)

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 the reviewer that the request for a left L5-S1, S1, S2, S3 RFTC is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

MRI lumbar spine 05/03/13

Clinical notes 06/07/13 and 06/24/13

Previous utilization reviews 06/20/13 and 07/10/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female with a reported injury to her lumbosacral region. Lumbar MRI on 05/03/13 revealed moderate chronic dehydration and degenerative changes within the L5-S1 disc space. Moderate facet arthropathy changes were noted at both the L4-5 and L5-S1 levels. Clinical note dated 06/07/13 detailed the patient complaining of intractable lumbosacral pain that was non-response to medications and conservative treatment. The patient underwent sacral medial branch block with IV sedation and fluoroscopic guidance. The patient tolerated the procedure well. Clinical note dated 06/24/13 reported 60% relief following the medial branch block in the lumbosacral region. However the patient noted a return of pain that was rated as 9/10. Tenderness to palpation was noted at the left greater trochanter and piriformis muscles. Pain radiated to the left ankle, calf, foot, knee, shin, and thigh. Previous utilization review dated 06/20/13 for a radiofrequency thermocoagulation at L5-S1, S1, S2, S3 on the left resulted in a denial secondary to the specific findings of pain radiating to the left lower extremity. Previous utilization review dated 07/10/13 for radiofrequency thermocoagulation at L5-S1, S1, S2, and S3 resulted in denial secondary to pain radiating to the left lower extremity.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The clinical notes specifically point out the patient's complaints of pain radiating into the left lower extremity all the way to the foot. Guidelines recommend radiofrequency thermocoagulation following a diagnostic procedure

indicating a positive response and ongoing symptomology indicates the need for a radiofrequency thermocoagulation. Given the significant clinical findings involving the complaints of pain radiating to the left foot this request for a radiofrequency thermocoagulation at L5-S1 through S3 on the left is not indicated as medically necessary. As such it is the opinion of the reviewer that the request for a left L5-S1, S1, S2, S3 RFTC 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

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)