C-IRO Inc.

An Independent Review Organization
1108 Lavaca, Suite 110-485
Austin, TX 78701
Phone: (512) 772-4390
Fax: (512) 519-7098
Email: resolutions.manager@ciro-site.com

NOTICE OF INDEPENDENT REVIEW DECISION

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

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: outpatient radiofrequency (RF) at the L2-3 and L5-S1 levels with fluoroscopy and anesthesia

A 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:

[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 <u>each</u> health care service in dispute. It is the opinion of this reviewer that the request for outpatient radiofrequency (RF) at the L2-3 and L5-S1 levels with fluoroscopy and anesthesia does not meet Official Disability Guidelines criteria and medical necessity is not established

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
ODG - Official Disability Guidelines & Treatment Guidelines
IRO request/referral documents
Notice of utilization review findings dated 12/21/12
Notice of utilization review findings dated 01/17/13
Pre-authorization request dated 12/17/12
Progress note dated 12/12/12
Pre-authorization reconsideration request dated 01/10/13

PATIENT CLINICAL HISTORY [SUMMARY]: The claimant is a male who is noted to have sustained a lifting injury to his low back on xx/xx/xx. The patient has a history of previous lumbar fusion at L3-L5 in 1995 and 2001 with subsequent hardware removal in 2002. Records indicate that the claimant also underwent additional removal of hardware and exploration of fusion in 2004. He had a RACZ procedure on 02/05/09. A spinal cord stimulator was implanted in 12/09. The claimant was seen on 12/12/12 with complaints of back pain. He complains of pain located in the back, bilateral hips, and bilateral buttocks. On examination, the claimant was noted to be 69” tall and 190 lbs. (BMI = 28.06). The claimant was noted to be well-nourished and well-hydrated and in no acute distress.

A request for outpatient radiofrequency (RF) injection at L2-3 and L5-S1 with fluoroscopy and anesthesia was reviewed on 12/21/12 and non-authorized as medically necessary. It was noted that the previous request for left lumbar medial branch blocks above and below the

spinal fusion were not authorized in 12/09 and 01/12. Right RF was non-authorized in 11/11 and 02/12. It was noted that previous requests for diagnostic medial branch blocks was not authorized as medical necessity was not established in the documentation presented.

A reconsideration request was reviewed on 01/17/13 and was again non-authorized. It was noted that it appears the claimant has had diagnostic medial branch blocks. On the right he had a 50% decrease in pain (duration not given), but he now feels pain which originates in the hip. On the left, it made his pain worse. The reviewer noted that based on this alone, there is no reason to perform a RF procedure. It was further noted that the claimant had a spinal cord stimulator and that RF is basically contraindicated.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The claimant sustained an injury to the low back in 2002 secondary to lifting. He has a history of multiple lumbar surgeries including L3-5 fusion with subsequent hardware removal. The claimant also underwent a spinal cord stimulator implantation. There is no documentation concerning the dates and response to previous diagnostic medial branch blocks. There is inconsistent information regarding diagnostic medial branch blocks. The progress note dated 12/12/12 does not indicate the dates, extent, or duration of lumbar facet medial branch block, noting only that the patient had "good relief." There is no detailed physical examination with findings consistent with facet-mediated pain. Based on the clinical information provided, it is the opinion of this reviewer that the request for outpatient radiofrequency (RF) at the L2-3 and L5-S1 levels with fluoroscopy and anesthesia does not meet Official Disability Guidelines criteria and medical necessity is not established.

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)