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NOTICE OF INDEPENDENT REVIEW DECISION

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

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Lumbar RF MBB at L5-S1 and S1-S2

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

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
ODG - Official Disability Guidelines & Treatment Guidelines
MRI of the lumbar spine dated 02/24/11
Clinical notes dated 11/07/12 – 05/30/13
Previous utilization reviews dated 06/04/13 & 06/21/13

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a male who reported an injury regarding his low back. The MRI of the lumbar spine dated 02/24/11 revealed an annular disc bulge at L4-5 with bilateral facet hypertrophy. An annular disc bulge with mild bilateral facet joint hypertrophy was noted at L1-2, L2-3, and L3-4 with no significant nerve root impingement. The clinical note dated 11/07/12 details the patient continuing with complaints of low back pain. The patient was recommended for a medial branch block at that time. The note does detail the patient utilizing Norco, Gabapentin, and Celebrex for ongoing pain relief. The patient rated his pain as 5/10 at that time. The clinical note dated 02/07/13 details the patient stating that the previous radiofrequency procedure performed on 01/25/13 resulted in 60% pain relief. However, a return to pain was noted which was aggravated with an increase in physical activity. The patient reported a pain level of 3/10 at that time. The clinical note dated 04/08/13 details the patient stating that he had done well following the radiofrequency procedure; however, for the previous 3 weeks, the patient noted an increase in back pain. The clinical note dated 05/30/13 details the patient continuing with low back complaints. The patient noted a gradual return of pain in the low back despite the previous radiofrequency ablation. The patient stated that no radiation of pain was noted. The patient rated his pain as 4/10 at that time.

The previous utilization review dated 04/03/13 for a radiofrequency procedure at the L5-S1 and S1-S2 levels resulted in a denial secondary to the patient receiving an inadequate response to the previous radiofrequency ablation.

The utilization review dated 06/21/13 for a radiofrequency ablation at L5-S1 and S1-S2 resulted in a denial as the length of time the patient had received significant pain relief did not meet the necessary guideline criteria.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The documentation submitted for review elaborates the patient complaining of ongoing low back pain. The Official Disability Guidelines recommend the use of a radiofrequency ablation in the lumbar region provided the patient meets specific criteria to include a positive response from the previous radiofrequency ablation along with an objective functional improvement. The documentation does detail the patient reporting 60% pain relief. However, the length of time the patient received significant pain relief presents as being inadequate as Official Disability Guidelines specifically recommend a 12 week response to pain relief, whereas the patient reported a 5 week reduction in pain. Given the inadequate response to the previous radiofrequency ablation, this request does not meet guideline recommendations. As such, it is the opinion of this reviewer that the request for a radiofrequency ablation at L5-S1 and S1-S2 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)