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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Feb/26/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: radiofrequency ablation 64640 x 2

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:

- 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 this reviewer's opinion that the request for radiofrequency ablation 64640 x 2 is not medically necessary

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Clinical notes by Dr. dated 01/06/11 – 05/05/11
Clinical note by Dr. dated 06/30/11
Clinical note by Dr. dated 07/07/11
Clinical notes by Dr. dated 08/11/11 – 09/29/11
Clinical notes by Dr. dated 11/30/11 and 10/24/12
Clinical note by Dr. dated 12/26/12
Procedure note by Dr. dated 01/02/13
Appeal letter dated 01/21/13
Prior reviews dated 01/14/13 and 02/04/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who sustained an injury to the left lower extremity that resulted in a below the knee amputation. The patient is noted to have developed an abscess at the residual left lower extremity limb that required antibiotic treatment. The patient was recommended for a cyst removal at the residual left lower extremity limb in 08/11. The patient was seen by Dr. on 12/26/12 for steadily increasing pain in the residual left lower extremity limb. Physical examination revealed a lower extremity prosthetic in the left lower extremity that was in fair condition. Range of motion of the left knee was full with some crepitus present. There was extensive scarring of the amputation stump with the presence of 2 small masses, one lateral and one posterior, that were tender to palpation. The patient was recommended for mapping to define pain generators. The patient underwent diagnostic blocks of the neuromas on 01/02/13. The patient reported immediate post-injection relief and was able to ambulate appropriately with the prosthesis.

The request for radiofrequency ablation was denied by utilization review on 01/14/13 as there was no documentation regarding duration of relief with the nerve blockade.

The request was again denied by utilization review on 02/04/13 as it was unclear what the patient's actual diagnostic response was to the injections and there were no long-term studies indicating the effectiveness of this treatment.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient did report significant pain relief immediately following the injections per the procedure note dated 01/02/13; however, there are no further clinical notes provided for review establishing the exact level of pain relief sustained by the patient that would support radiofrequency procedures at this point in time. The appeal letter presented for review indicated that the prior denials were not based on the patient's diagnosis; however, the prior reviewers identified that a lack of documentation regarding response to the injections was their primary reason for non-certification. Given the insufficient clinical documentation regarding the patient's response to the injections, radiofrequency ablation of the suspected neuromas at the amputation site would not be supported at this point in time. As such, it is this reviewer's opinion that the request for radiofrequency ablation 64640 x 2 is not medically necessary and the prior denials are upheld.

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)

Restrepo-Garces, C. E., Marinov, A., McHardy, P., Faclier, G. and Avila, A. (2011), Pulsed Radiofrequency Under Ultrasound Guidance for Persistent Stump-Neuroma Pain. Pain Practice,

11: 98–102.

Gekht, G., Nottmeier, E. W. and Lamer, T. J. (2010), Painful Medial Branch Neuroma Treated with Minimally Invasive Medial Branch Neurectomy. *Pain Medicine*, 11: 1179–1182.