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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Nov/03/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: left L3-L4 radiofrequency ablation using fluoroscopy

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

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 this reviewer that the records would not support a left L3-L4 radiofrequency ablation using fluoroscopy at this time

PATIENT CLINICAL HISTORY [SUMMARY]: This patient is a female. On 03/10/11, an MRI of the lumbar spine revealed mild multi-level spondylosis of the lumbar spine but there is no significant canal stenosis in the lumbar spine as seen by reading radiologist. However, the neuroforamina bilaterally at L3-4 was mildly encroached upon secondary to osteophytes and an annular disc bulge. The exiting L3 nerve root sheaths bilaterally were barely contacted but not frankly compressed. On 05/05/11, this patient was taken to surgery for a lumbar epidural steroid injection, lysis of adhesions, under fluoroscopic guidance. On 06/15/11, this patient was given a BHI #2, enhanced interpreted report and the psychosocial screen noted the patient was worse than average with regard to intrinsic job dissatisfaction scale and the entitlement subscale and neither of those would put this patient at risk for barriers to recovery. On 08/09/11, the patient was taken to surgery for a lumbar medial branch L3 and L4 to the left. On 11/07/11, this patient was taken back to surgery for a lumbar medial branch RFA at L3 and L4 to the left. On 01/27/14, this patient was given a lumbar medial branch RFA at L3, L4 bilaterally. On 08/19/14, this patient was seen back in clinic, and straight leg raise elicited back pain and there was a positive Kemp sign. Her lower extremity motor strength was weakened in both lower extremities and sensation was intact. Reflexes were 2+ at the patella and at the Achilles. On 10/01/14, a letter of medical necessity for the submitted request for a left L3-4 radiofrequency ablation using fluoroscopy was submitted, noting the patient had experienced radiofrequency ablation on the left 2 times in the past both of which gave her good temporary results. The left L3-4 was addressed on 11/07/12 and on 01/27/14 and it was noted both times gave her good temporary relief.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The submitted records indicate this patient has been submitted for a left L3-4 radiofrequency ablation under fluoroscopy. The submitted records indicate she underwent this procedure on 01/27/14 after having undergone a previous left RFA at the L3 and L4 facet nerves on the left on 11/07/12. The Official Disability Guidelines indicate that while repeat neurotomies may be required, they should not occur at an interval of less than 6 months for the 1st procedure and a neurotomy should not be repeated unless duration of relief from the 1st procedure is documented for at least 12 weeks at greater than 50% relief. It was also noted that the current literature does not support the procedure being successful without sustained pain relief generally of at least 6 months duration. Repeat neurotomies should document evidence of adequate diagnostic blocks, documented improvement in VAS score, decreased medications and documented improvement in function. It was noted that there should also be evidence of a formal plan of additional evidence based conservative care in addition to facet joint therapy. The submitted records indicate that the patient has lower extremity motor strength weakened in both lower extremities, and has stated this is mostly due to her back pain. As such, there may be a component of radiculopathy on her clinical exam of 08/19/14 for which a facet procedure would not be recommended. The records do not describe as recommended by guidelines, documented changes in VAS scores documented greater than 50% relief for 12 weeks as recommended or for 6 weeks as also recommended by guidelines. Therefore, it is the opinion of this reviewer that the records would not support a left L3-L4 radiofrequency ablation using fluoroscopy at this time and the recommendation is for upholding the previous determinations.

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)