Pure Resolutions LLC

An Independent Review Organization

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Notice of Independent Review Decision

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Physical Medicine and Rehabilitation

Description of the service or services in dispute:

Radiofrequency Neuro albation of the left L4, L5 and S1 of the lumbar spine

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)

Patient Clinical History (Summary)

Patient is a female. On xx/xx/xx, the patient was taken to surgery for #1 medial branch block left L4, L5, and S1. On xxxx, the patient was taken back to surgery for a radiofrequency ablation left L4, L5, and S1 medial branches. On xxxx, the patient was taken back to surgery for a radiofrequency ablation left L4, L5, and S1 medial branches. On xxxx, the patient was taken back to surgery for a radiofrequency ablation left L4, L5, and S1 medial branches. On xxxx, the patient was taken back to surgery for a radiofrequency ablation left L4, L5, and S1 medial branches. On xxxx, the patient was taken back to surgery for radiofrequency ablation left L4, L5, and S1 medial branches. On xxxx, the patient returned to clinic with complaints of low back pain and left hip and buttock pain. She reported 50% relief from the last radiofrequency ablation until xxxx of xxxx. On exam, tenderness to palpation about the bony aspects of L4-5 and L5-S1 was noted to be increased and she was to be planning for a repeat radiofrequency ablation left L4, L5, and S1 medial branches.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

On xxxx, a utilization review report was submitted noting the requested procedure had been non-certified. Guidelines used included the Official Disability Guidelines. It was noted the guidelines indicate that medial branch blocks should be conducted at the same levels previous to the planned RF procedure, and there is no demonstration in the records of a recent medial branch block. There was also a lack of information regarding compliance with a daily home exercise program to maximize conservative care previous to the requested procedure. Therefore the request was non-certified. On xxxx, a utilization review report was submitted using the Official Disability Guidelines as the citing reference noting that approval of repeat neurotomies depends on variables such as evidence of adequate diagnostic blocks, documented improvement in VAS score, decreased medications and documented improvement in function and this was not established in the patient's case as there was no clear long term treatment described for this patient. There was a lack of documentation showing one of these procedures was performed when the patient described radicular pain. Therefore the request was non-certified.

The Official Disability Guidelines were utilized for this review indicating this procedure is intended for those patients with low back pain without radicular symptoms. Repeat neurotomies should be based on functional

improvement, decreased medication usage and decreased pain scores objectively. Medial branch blocks should be performed prior to neurotomies. The records do not indicate that a recent medial branch block has been performed, do not indicate that the patient has undertaken recent conservative measures such as physical therapy or a home exercise program. Therefore it is the opinion of this reviewer that the request for a radiofrequency ablation neural ablation of left L4, L5, and S1 of the lumbar spine was 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 and Environmental Medicine um
- ☐ knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and
- ☐ Guidelines European Guidelines for Management of Chronic
- ☐ Low Back Pain Interqual Criteria
- ☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- ☐ standards Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☑ ODG-Official Disability Guidelines and Treatment
- ☐ Guidelines Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and Practice
- ☐ Parameters Texas TACADA Guidelines
- ☐ TMF Screening Criteria Manual
- ☐ Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
- ☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)