MAXIMUS Federal Services, Inc.
807 S. Jackson Road, Suite B
Pharr, TX 78577
Tel: 956-588-2900 ◆ Fax: 1-877-380-6702

Notice of Independent Medical Review Decision
Reviewer's Report

DATE OF REVIEW: 5/1/18
IRO CASE #: XXXXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Bilateral L4-5 lumbar sacral radiofrequency thermocoagulation (RFTC) 64635 x 2, fluoroscopy 77003 and sedation 99152/99153.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
M.D., Board Certified in Physical Medicine & Rehabilitation with sub-specialty certification in 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)

I have determined that the requested bilateral L4-5 lumbar sacral radiofrequency thermocoagulation (RFTC) 64635 x 2, fluoroscopy 77003 and sedation 99152/99153 are not medically necessary for the treatment of the patient's medical condition.

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is XX with a history of an occupational claim from XXXX. The mechanism of injury is detailed as XX. The pertinent prior treatments included physical therapy, medications, spinal cord stimulator, and multiple radiofrequency ablations, including the most recent radiofrequency ablation on XXXX. The patient underwent a laminectomy in XXXX. The pertinent diagnoses included radiculopathy, lumbar region, post-laminectomy syndrome, not elsewhere classified and chronic pain syndrome. The records document low back pain that radiated to the bilateral hips, legs and groin area. The treatment plan included radiofrequency thermocoagulation (RFTC). A request has been submitted for bilateral L4-5 lumbar sacral radiofrequency thermocoagulation (RFTC) 64635 x 2, fluoroscopy 77003 and sedation 99152/99153.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

The Official Disability Guidelines indicate that radiofrequency thermocoagulation (RFTC) is not recommended as an effective treatment in reducing chronic discogenic low back pain. In this case, the records document chronic discogenic low back pain. The patient had previously undergone radiofrequency ablations, and the documentation supported the patient had functional benefit and pain relief for one year. The requested procedure is not recommended per the referenced guidelines. There was no rationale for the use of sedation. There were no exceptional factors noted to warrant nonadherence to guideline recommendations. Thus, the requested services are not medically necessary per Official Disability Guidelines.

Therefore, I have determined the requested bilateral L4-5 lumbar sacral RFTC 64635 x 2, fluoroscopy 77003 and sedation 99152/99153 are not medically necessary for treatment of the patient's medical condition.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN 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 JUDGMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

Official Disability Guidelines & Treatment Guidelines, 16th Edition (Web), 2018. Low Back Chapter, Percutaneous Intradiscal Radiofrequency (Thermocoagulation).

- ☐ **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)**