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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Sep/04/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar right medial branch block with fluoroscopy

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

M.D. Board Certified Orthopedic Surgeon

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)

PATIENT CLINICAL HISTORY SUMMARY

The patient is a female. She injured her lower back. MRI of the lumbar spine dated 02/09/06 revealed a 2-3 mm central disc bulge versus protrusion at L5-S1 with slight desiccation of the disc material. EMG/NCV dated 02/21/06 revealed findings consistent with radiculopathies involving the left L5 and S1 nerve roots. The patient completed at least 30 sessions of physical therapy. Diagnosis is reported as low back pain with radiculopathy. The patient underwent LESI left L5, S1 on 04/24/06, and had an adverse reaction with vomiting and feeling very sick. RME dated 06/16/06 reports that the injury consisted of lumbar strain only. Designated doctor evaluation dated 10/20/06 indicates that the patient reached MMI as of 06/15/06 with 10% whole person impairment. Consultation dated 09/22/08 reports diagnosis of lumbar radiculopathy. Designated doctor evaluation dated 10/05/09 indicates that there is no objective evidence of an injury to her back, to her legs or to any other part of her body. The medical records contain no evidence at all that she ever had a significant back injury. Orthopedic report dated 04/11/11 reports the patient experienced radiculitis in the right lower extremity and a lumbar epidural steroid injection will be requested which was subsequently denied. Orthopedic report dated 07/05/11 indicates that the patient has been recommended for surgical intervention; however, requests for lumbar discogram have been non-certified. The patient complains of low back pain with intermittent pain radiating down both lower extremities with numbness and tingling. On physical examination there is tenderness in the lower lumbar region. Straight leg raising is mild on the right and negative on the left. Motor strength is weakened in both lower extremities mostly due to her back pain. She continues to have paresthesias in the lateral aspect of the bilateral lower extremities. Deep tendon reflexes are 2+ throughout.

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

RME dated 06/16/06 reports that the injury consisted of lumbar strain only. Designated doctor evaluation dated 10/20/06 indicates that the patient reached MMI as of 06/15/06 with 10% whole person impairment. Designated doctor evaluation dated 10/05/09 indicates that there is no objective evidence of an injury to her back, to her legs or to any other part of her body. The medical records contain no evidence at all that she ever had a significant back injury. The submitted medical records consistently report a diagnosis of radiculopathy, and the Official Disability Guidelines only recommend medial branch blocks for patients with low back pain that is non-radicular. Given the current clinical data, the requested Lumbar right

medial branch block with fluoroscopy is not found by the reviewer to be 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

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)