

SENT VIA EMAIL OR FAX ON
Feb/27/2012

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Feb/24/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right L3-L5 Medial Branch Block

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

PMR

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

Cover sheet and working documents

Utilization review determination dated 01/25/12, 02/15/12

Consultation dated 06/03/11

Supplemental charting notes dated 01/31/11

Office visit note dated 01/20/12, 09/09/11, 12/23/11, 11/28/11, 10/24/11, 07/21/11

Procedure note dated 12/07/11, 01/04/12

Laboratory report dated 10/24/11, 01/20/12

Radiographic report dated 06/03/11

Handwritten note dated 04/15/11

Behavioral medicine evaluation dated 06/27/11

Electrodiagnostic studies dated 05/18/11

MRI lumbar spine dated 01/25/11

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male whose date of injury is xx/xx/xx. On this date the patient was working on a tractor when it fell into a large hole. MRI of the lumbar spine dated 01/25/11 revealed central disc extrusion at L3-4 extending approximately 5 mm posterior and 6 mm inferior to the endplates with flattening of the anterior thecal sac, but no significant spinal canal stenosis. There is ligamentum flavum and articular facet hypertrophy with mild bilateral neural foraminal stenosis, right greater than left. At L4-5 there is a mild 2-3 mm posterior annular disc bulge as well as posterior osteophyte formation with right inferior neural foraminal encroachment. Combined with ligamentum flavum and articular facet hypertrophy, this results in mild bilateral neural foraminal stenosis. At L5-S1 there is a mild 2 mm posterior annular disc bulge and posterior osteophyte formation as well as articular facet hypertrophy with mild left neural foraminal stenosis. No significant spinal canal stenosis is seen. A right L5 pars defect is noted. Electrodiagnostic studies dated 05/18/11 revealed suspect modest but significant right L5 greater than L4 radiculitis and mild left S1 radiculitis. Consultation dated 06/03/11 notes that the patient has undergone chiropractic treatment, physical therapy and 5 epidural steroid injections to date. The patient underwent right L5 transforaminal epidural steroid injection on 12/07/11 and right L4 transforaminal epidural steroid injection on 01/04/12. Follow up note dated 01/20/12 indicates that the patient reports 80% reduction in his right leg pain. Medications include aspirin, Tramadol, acetaminophen-Hydrocodone, Naproxen and Omeprazole. On physical examination thoracolumbar spine flexion and extension were abnormal.

Initial request for right L3-L5 medial branch block was non-certified on 01/25/12 noting that other indicators of pain related to facet joint pathology (e.g. tenderness at paravertebral areas, sensory exam that is normal, straight leg raising exam which is normal) were not documented per latest physical examination to warrant a diagnostic facet joint block. Additionally, the submitted reports do not include objective documentation of failure to respond to conservative treatment, such as rehabilitation and oral pharmacotherapy. The denial was upheld on appeal dated 02/15/12 noting that the most recent physical examination dated 01/20/12 still did not include the presence of facet joint pathologies such as tenderness to palpation over the facet region, normal sensory examination, absence of radicular findings and normal straight leg raising. As per guidelines, facet joint injections are limited to those with low back pain that is non-radicular. There was a note of subsequent neurotomy, as per 01/20/12 report; however, the medical records sent for review still failed to document exhaustion of other recommended conservative treatments such as physical therapy and oral pharmacotherapy. The objective response through PT progress notes and VAS pain scales was not provided. The active treatment program in conjunction with the injection blocks was also not mentioned.

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

Based on the clinical information provided, the request for right L3-L5 medial branch block is not recommended as medically necessary, and the two previous denials are upheld. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. There is no current, detailed physical examination submitted for review to establish the presence of facet pathology. The most recent physical examination submitted for review dated 01/20/12 notes only thoracolumbar spine flexion, lateral flexion to the right and extension were abnormal. The Official Disability Guidelines support medial branch blocks for patients with low back pain that is non-radicular. This patient has been diagnosed with radiculopathy which is corroborated by electrodiagnostic testing.

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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES