

# US Resolutions Inc.

An Independent Review Organization

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Nov/26/2013

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** lumbar facet block injection under fluoroscopy at right L5-S1 as outpatient

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** M.D., Board Certified Anesthesiology and 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)

**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 the reviewer that the request for lumbar facet block injection under fluoroscopy at right L5-S1 as outpatient as outpatient is not recommended as medically necessary.

### INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Utilization review determination dated 09/27/13, 10/15/13

Office visit note dated 09/19/13, 08/22/13, 10/03/13

MRI lumbar spine dated 09/06/13

Progress note dated 08/07/13, 08/06/13, 07/31/13, 07/29/13, 07/25/13, 07/24/13, 07/16/13, 08/21/13, 08/28/13, 09/13/13, 09/25/13

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male whose date of injury is xx/xx/xx. The patient injured his lower back on the left side. The patient completed a course of physical therapy with minimal or no help. Per note dated 08/22/13, diagnoses are listed as lumbar strain, lumbar facet/disc pain, lumbar herniated nucleus pulposus and lumbar radiculopathy. MRI of the lumbar spine dated 09/06/13 revealed at L5-S1 there is no evidence of disc herniation or significant disc bulge; no central or lateral canal stenosis is seen. Office visit note dated 09/19/13 indicates that the patient complains of low back pain that does not radiate. Progress note dated 09/25/13 indicates that the patient has been working regular duty and he feels the pattern of symptoms is worsening. On physical examination straight leg raising is negative bilaterally in the seated position. Lumbar range of motion is decreased to flexion and extension. It appears that the patient underwent facet injections on 10/03/13.

Initial request for lumbar facet block injection at right L5-S1 was non-certified on 09/27/13 noting that the most recent evaluation indicated that no significant change from the previous examination was noted. The previous examination documented findings of radiculopathy such as positive straight leg raising and diminished deep tendon reflexes in both lower

extremities. The provided medical records did not document failure of conservative treatment with NSAIDs, home exercises or physical therapy. The denial was upheld on appeal dated 10/15/13 noting that the records appear to reflect that there has been a facet block already completed. Therefore, when noting the treatment plan parameters outlined in the ODG, only one set of medial branch blocks is indicated prior to a facet neurotomy.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient sustained a low back injury on xx/xx/xx and subsequently underwent a course of physical therapy as well as facet injections on 10/03/13. The Official Disability Guidelines support one set of diagnostic facet blocks and do not support a second confirmatory block. As such, it is the opinion of the reviewer that the request for lumbar facet block injection under fluoroscopy at right L5-S1 as outpatient as outpatient is not recommended as 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)