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An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jul/07/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Left L4-5 and L5-S1 medial branch block with fluoroscopy

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Orthopedic Surgery

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

MRI of the lumbar spine dated 11/14/13

MRI of the cervical spine dated 02/13/14

Clinical report dated 12/12/13

Clinical report dated 01/09/14

Clinical report dated 01/30/14

Clinical report dated 02/21/14

Clinical report dated 02/27/14

Clinical report dated 03/20/14

Clinical report dated 04/15/14

Clinical report dated 04/17/14

Clinical report dated 05/19/14

Urine toxicology report dated 02/26/14

Drug metabolism genetic profile report dated 03/09/14

Clinical report dated 10/17/13

Physical therapy report dated 10/17/13

Physical therapy report, illegible date

Prior utilization review reports dated 03/31/14 & 04/28/14

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who was involved in a motor vehicle accident on xx/xx/xx. The patient developed complaints of both neck and low back pain. Conservative treatment did include both physical therapy and the use of medications to include anti-inflammatories, oral steroids, muscle relaxers, and analgesics. MRI studies of the lumbar spine from 11/14/13 noted no evidence of neurocompression due to disc pathology. The patient denied any complaints of radicular symptoms in the lower extremities. Following the patient's MRI studies, the patient was recommended for epidural steroid injections. The patient was seen on 02/21/14 with continuing complaints of low back pain

radiating to the left lower extremity. On physical examination, straight leg raise testing reported negative findings. There was tenderness noted in the lower lumbar spine. The patient did describe pain with lumbar range of motion. recommend diagnostic facet joint injections at this evaluation. Per the report, there was pain with hyperextension and rotation of the lumbar spine consistent with facet mediated pain and the patient did have a positive Kemp's maneuver for facet mediated pain. Follow up on 04/15/14 indicated the patient continued to have complaints of low back pain radiating to the left lower extremity. The patient reported that medications had been effective with no significant side effects. On physical examination, there was a positive Fabre's sign to the left with tenderness to palpation noted in the lower lumbar spine. Straight leg raise findings continued to be negative. The patient was again recommended for diagnostic medial branch blocks. The reports indicated that if the patient had a positive response to medial branch blocks, this would improve pain and allow for a decrease in medications. The most recent evaluation on 05/19/14 indicated the patient was still pending approval for diagnostic facet blocks. The patient was noted to be utilizing Gabapentin which was reported as helpful. No evidence of neurological deficit was identified on physical examination.

The requested medial branch blocks to the left from L3 through S1 were denied by utilization review on 03/31/14. Per the comments, the patient did not have any clear objective findings regarding facet loading on physical examination and no documentation regarding lower levels of care such as a home exercise program. also noted that guidelines do not recommend medial branch blocks at more than 2 joint levels at one time.

The request for left L4-5 and L5-S1 medial branch blocks was denied by utilization review on 04/28/14 again. Per his comments, there was evidence regarding possible radiculopathy without evidence of true facet mediated pain and full documentation regarding conservative treatment.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient has been followed for ongoing complaints of low back pain radiating to the left lower extremity. Originally, the patient denied any lower extremity symptoms; however, after MRI studies noted a disc protrusion without nerve compromise, the patient complained of bilateral lower extremity symptoms. originally recommended epidural steroid injections for this patient. The patient was seen and reported to have pain with lumbar hyperextension and rotation consistent with facet mediated pain. that the patient did not present with any clear objective evidence regarding lumbar radiculopathy which was also noted in reports. In this case, there is documentation regarding failure of conservative treatment as the patient has attended both chiropractic and physical therapy and utilized multiple medications without long term improvement. The clinical documentation submitted for review however does not indicate whether the patient would be considered for facet rhizotomy procedures following medial branch blocks. reports indicate that the primary rationale behind performing medial branch blocks was to reduce pain and allow for a decrease in medication and to allow the patient to participate in physical therapy. Per guidelines, the only indication for medial branch blocks is to determine pain generators for consideration regarding facet rhizotomy. Guidelines do not recommend facet joint or medial branch block injections as a therapeutic modality to decrease pain and improve function. Given that the indications provided regarding the medial branch blocks are not consistent with guideline recommendations, it is this reviewer's opinion that medical necessity in this case has not been established. Therefore, 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 & 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)