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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

June/12/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar facet block diagnostic bilaterally at L4-S1

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

Board Certified Anesthesiologist

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:

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who reported an injury to her low back. No information was submitted regarding initial injury. A clinical note dated xxxx indicated the patient complaining of 5-10/10 pain. The patient stated the pain was worse upon waking each morning. The patient stated the pain was affecting her activities of daily living. Upon exam reflexes were absent at both patella and Achilles. The patient was unable to heel or toe walk at that time. The MRI of the lumbar spine dated xxxx revealed compression of superior endplate of L5. Disc height loss of approximately 10% was identified. A compression fracture involving the pedicles was also identified at L4-5. 3mm anterolisthesis of L5 was identified on S1. A CT scan of the lumbar spine dated 07/31/13 revealed mild bilateral facet arthropathy at L4-5. Mild posterior disc bulge was also identified at L5-S1. A clinical note dated 05/19/14 indicated the patient continuing with 5-10/10 pain. The patient demonstrated 55 degrees of lumbar flexion and 10 degrees of 5 degrees of extension with bilateral 10 degrees of bilateral lateral flexion. Tenderness was identified at L4-5 and L5-S1 facets. Pain radiated into the back, buttocks, hip thigh and leg. Patient was recommended for facet diagnostic facet injection. The Utilization review dated 03/27/14 resulted in denial for facet diagnostic facet injection as the patient was identified as having no clinical documentation regarding low back pain being non-radicular in nature. No information was submitted regarding completion of any conservative treatment.

The Utilization review dated 04/30/14 resulted in a denial for similar reasons.

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

The request for diagnostic facet block bilaterally at L4 through S1 is non-certified. The clinical documentation indicates the patient complaining of low back pain radiating into lower extremities. Facet diagnostic facet blocks are indicated for patients with low back pain that is non-radicular in nature following a full course of conservative treatment. The documentation submitted for review indicates the patient complaining of low back pain radiating to the lower extremities. No information was submitted regarding completion of conservative treatment. Therefore this request is not indicated. As such, it is the opinion of this reviewer that the request for diagnostic lumbar facet block bilaterally at L5-S L4 through S1 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 KNOWLEDGBASE

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)