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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Mar/20/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: ultrasound sono guide, injection nerve block

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O., Board Certified Physical Medicine and Rehabilitation 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 this reviewer that the request for ultrasound sono guide, injection nerve block is recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Clinical notes xx/xx/xx
Clinical notes 10/08/12
Clinical notes 10/08/13
Clinical notes 12/03/13
Clinical notes 12/17/13
Clinical notes 01/29/13
Clinical notes 02/11/14
Adverse determination 02/19/14

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who reported an injury to his low back. Admission note dated xx/xx/xx indicated the patient complaining of low back and left thigh pain. The patient stated that he had a seven month history of low back and thigh pain. The patient returned to regular duty. Low back pain was resolved by that time. MRI of the lumbar spine revealed disc desiccation at L2-3 with an annular tear and disc protrusion at L5-S1 indenting the ventral thecal sac. Clinical note dated 01/29/13 mentioned the patient undergoing physical therapy and injections at the left groin. No significant benefit resulted from the conservative treatment. The patient described the pain as a burning and stinging sensation. The patient reported numbness and tingling in the lower extremities. The patient utilized Trileptal. Clinical note dated 10/08/13 mentioned the patient having 1-2/10 pain. Hypersensitivity along with tingling was identified at the left thigh. Clinical note dated 12/03/13 mentioned the patient sleep affected by the ongoing pain. Clinical note dated 12/17/13 indicated the patient undergoing epidural steroid injections and additional physical therapy addressing low back pain. The patient stated he was unable to sleep for a prolonged

period of time secondary to the pain. Clinical note dated 02/11/14 mentioned the patient having impaired sensation over the left L1 through L3 dermatomes with hypersensitivity proximally and a decrease distally. The patient was recommended for continued use of capsaicin cream and tramadol and diagnostic ultrasound of the left lateral femoral cutaneous nerve as well as a possible steroid injection. Utilization review dated 02/19/14 resulted in denial as there was a lack of correlation with the electrodiagnostic results and physical examination findings to support an injection at this time.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: Clinical documentation indicates the patient continuing to complain of low back and thigh pain. The use of injection therapy at the femoral nerve would be indicated provided that the patient meets specific criteria, including significant clinical findings noted by exam confirming a femoral nerve involvement. The clinical documentation indicates the patient showing clinical signs confirming the left femoral involvement. Femoral nerve stretch resulted in positive findings of left thigh pain. Additionally increase in sensitivity was identified at the lateral region of the left thigh. Given these findings, the requested lateral femoral cutaneous nerve injection with ultrasound guidance is indicated as medically necessary. As such, it is the opinion of this reviewer that the request for ultrasound sono guide, injection nerve block is 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)