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An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Dec/18/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: outpatient left lumbar medial branch block at L4-5 and L5-S1

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 the reviewer that the request for outpatient left lumbar medial branch block at L4-5 and L5-S1 is not recommended as medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male whose date of injury is xx/xx/xx. On this date the patient fell. He had a previous foraminotomy performed in 2009 and underwent SI joint fusion in 2012. The patient underwent spinal cord stimulator placement in September 2013. Treatment to date is also noted to include lumbar medial branch blocks at L4-5 and S1 as well as rhizotomy procedures. Office visit note dated 11/10/14 indicates that chronic low back pain continues. There is occasional tingling in the left lateral extremity in the thigh, calf and the plantar foot. Spinal cord stimulator is on 24 hours a day. Physical therapy greater than 5 years ago worsens pain. On physical examination there is tenderness to palpation over the spinal processes of the mid to lower lumbar spine and paraspinals. Lumbar extension provokes low back pain. Left facet loading is positive greater than right. Strength is 5/5 in the bilateral lower extremities. Straight leg raising is negative bilaterally.

Initial request for outpatient left lumbar medial branch block at L4-5 and L5-S1 was non-certified on 11/14/14 noting that consideration should be given to updated diagnostic imaging studies in the form of CT myelography secondary to the patient having a spinal cord stimulator in place. With leg symptoms, the clinical scenario suggests a radiculopathy and not simply facet generated pain. The denial was upheld on appeal dated 11/26/14 noting that the most recent evaluation indicated the claimant was using tramadol and Elavil; however, failure of recent NSAIDs was not documented. It was also noted that physical therapy was attended greater than five years prior, which worsened pain, but there was no documentation of failure of recent physical therapy or home exercise program. Additionally, it was noted that the claimant had complained of tingling in the left lateral extremity, from the thigh to the foot.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND

CONCLUSIONS USED TO SUPPORT THE DECISION: The patient sustained injuries in xx/xxxx. There is no comprehensive assessment of recent treatment completed to date or the patient's response thereto submitted for review. Follow up note dated 11/10/14 indicates that physical therapy was completed greater than 5 years ago. The Official Disability Guidelines require documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks. The submitted records indicate that the patient has undergone prior lumbar medial branch blocks; however, the patient's objective functional response to these procedures is not documented to establish efficacy of treatment and support medial branch blocks at this time. As such, it is the opinion of the reviewer that the request for outpatient left lumbar medial branch block at L4-5 and L5-S1 is not recommended as medically necessary and 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 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)