

I-Resolutions Inc.

An Independent Review Organization
3616 Far West Blvd Ste 117-501
Austin, TX 78731
Phone: (512) 782-4415
Fax: (512) 233-5110
Email: manager@i-resolutions.com

DATE NOTICE SENT TO ALL PARTIES: Dec/29/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Left lumbar facet block L4-L5 L5/S1, Medial branch of the dorsal ramus

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: MD Board Certified Anesthesiologist
Board Certified 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 a left lumbar facet block L4-L5 L5/S1, Medial branch of the dorsal ramus is recommended for certification as medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female who reported an injury to her low back. The clinical note dated XX/XX/XX indicates the patient complaining of low back pain with radiating pain into the right lower extremity. The patient rated the pain as 4-6/10. The patient described the pain as a throbbing, aching and pinching sensation. The patient reported initial injury occurred when she fell inside of a walk in freezer resulting in the low back pain. The note indicates the patient had been working light duty at that time. There is indication the patient had previously undergone physical therapy with no significant benefit. The procedural note dated XX/XX/XX indicates the patient having undergone an epidural steroid injection at L5-S1. The therapy note dated XX/XX/XX indicates the patient having completed 5 physical therapy sessions to date. The MRI of the lumbar spine dated XX/XX/XX revealed a 6mm posterior central disc herniation and extrusion at L5-S1. An indentation of the thecal sac was identified as well as contact of the right and left S1 nerves. The clinical note dated XX/XX/XX indicates the patient having undergone a facet injection. The patient reported ongoing low back pain that was non-radiating at that time. The patient rated the pain as 4-6/10. The patient continued to work light duty. The clinical note dated XX/XX/XX indicates the patient presenting with no significant changes in the clinical presentation. The clinical note dated XX/XX/XX indicates the patient having been recommended for a facet injection at the L4, L5 and S1 levels. The utilization reviews dated XX/XX/XX and XX/XX/XX resulted in denials as insufficient information had been submitted regarding the patient's completion of any therapeutic interventions.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The documentation indicates the patient complaining of ongoing low back pain. The more recent clinical notes indicate the patient demonstrating low back pain as non-radiating in nature. A medial branch block is indicated for patients who continue with low back pain that is non-radicular in nature following the completion of a full course of conservative therapy. There is indication the patient had

completed 5 physical therapy sessions to date. Her previous epidural steroid injection had alleviated the patient's radicular symptoms. Given the ongoing non-radiating pain in the lumbar region and taking into account the previous attempts for more conservative therapy to include a course of physical therapy, the request is reasonable and recommended for certification. As such, it is the opinion of this reviewer that the request for a left lumbar facet block L4-L5 L5/S1, Medial branch of the dorsal ramus is recommended for certification as medically necessary and the prior denials are overturned.

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)