Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION
Workers' Compensation Health Care Network (WCN)

12/18/07

DATE OF REVIEW: **12/18/2007**

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Bilateral L3-S1 Facet Median Nerve Block

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
Texas State Licensed MD Board Certified Anesthesiology & Pain Management physician

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 or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW
1. Texas Dept of Insurance Assignment to 11/28/2007
2. Confirmation of Receipt of a Request for a Review by an IRO 11/27/2007
3. Company Request for IRO Sections 1-9 undated
4. Request for a Review by an IRO dated 11/26/2007
5. Letter to HWCN from dated 11/27/2007
6. Letter to IRO from dated 12/03/2007
7. ODG-TWC Low Back-Lumber & Thoracic (Acute & Chronic)
8. Adverse Determination Notice from Services Corp dated 11/07/2007
9. Adverse Determination After Reconsideration Notice dated 11/16/2007 from Services Corp
10. Office Visit Note from Dr. dated 11/02/2007
11. MRI of the lumbar spine w/o gadolinium contrast dated 07/19/2007
12. Medical Record Review from Dr. dated 11/04/2007
13. Report of Medical Evaluation dated 10/04/2007
14. Designated Doctor Evaluation (, MD) dated 10/04/2007
15. Medical Evaluators, Inc. dated 10/25/2007

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16. ODG Guidelines were not provided by the URA

PATIENT CLINICAL HISTORY:

This is a xx-year-old female who sustained a work related injury on xx/xx/xx involving neck, mid and low back, bilateral hip, knee and ankles secondary to a fall from a stool. Subsequent to the injury, claimant was treated conservatively with medication management and physical therapy and returned back to light duty on 6-21-2007.

Due to continued pain complaints, additional diagnostics were ordered with reported little improvement in neck, back, bilateral knee pain as well as radiation to the arms and legs. From the submitted designated doctor evaluation, claimant is complaining of pain in the cervical area, bilateral knees with decreased range of motion in both knees and numbness on occasion to the right leg and lateral hip of the right leg with associated weakness of the low extremities. The patient rates her pain score at a 10 on a scale of 1-10.

Aggravating factors include walking, bending, and squatting with her knees. From the requesting providers submitted followup note date November 2, 2007, the claimants medication profile consists of Vicoprofen one tablet PO Q 4-6 hours PRN (no more than four per day). Clinical examination of the lumbar spine from this followup note reveals range of motion full active with flexion, left lateral bending, right lateral bending, left rotation and right rotation; limited active range of motion with extension. Of note, observed range of motion of the lumbar spine as reported by the designated physician was within normal limits.

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

A review of the submitted lumbar MRI report dated 7-19-2007 reveals a trace amount of arthritic change of the lower lumbar spine facet joints but no significant central canal or neural foraminal stenosis at any of the levels and no disc bulges or protrusions; overall, no finding to explain the patient's back pain.

After review of the information provided, appears that this patient does not have a reasonable suspicion for lumbar facet joint pain.

There was no examination showing lumbar facet joints as per Dr. examination. The MRI shows no facet joint hypertrophy, only facet arthropathy which is a disease of maturation' not acute injury. There was mention made of myofascial pain in the lumbar paravertebral muscles and posterior superior ileac crest area, which appears to be the reason that the patient's low back is hurting. Therefore, there is no reason to perform a diagnostic facet based medial branch block, as there is not a reasonable suspicion for facet pain. Additionally, there is no mention that facet radial frequency oblation (RFA) are being considered.

Finally, from the subjective and objective findings, the clinical indication of the request could not be established.

Guideline references used: Acoem Guidelines, Second Edition, Chapter 12 & Official Disability Guidelines (ODG), Treatment Index, Fifth Edition, 2006/2007 on the low back – Diagnostic Facet Blocks.

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A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☒ **ACOEM- AMERICAN 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)**