

# US Decisions, Inc.

*An Independent Review Organization*

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## Notice of Independent Review Decision

**DATE OF REVIEW:** 07/28/2008

**IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

ACS services

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

M.D., Board Certified in Psychiatry with added board certifications in Pain Medicine and Forensic Psychiatry. This reviewer is licensed to practice medicine in Texas and has been in private practice for 26 years.

### **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)

Upon independent review the reviewer finds that the requested ACS services are not medically necessary.

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Adverse Determination Letters 6/11/2008, 7/2/2008  
ODG Guidelines and Treatment Guidelines  
Pre-Authorization Request  
Log Notes from 6/30/08 to 7/8/2008  
, MD 6/2/08, 4/28/08, 4/16/08  
MRI Lumbar Spine 3/17/2008

, MD 6/3/08  
, DC 6/16/08, 2/15/08  
Request for Reconsideration 6/3/08  
Center 3/27/08, 3/11/08, 3/3/08  
2/10/08  
Radiology Reports 2/18/08

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The injured worker is a xx y.o. male who is diagnosed with discogenic syndrome and lumbar spondylarthritis due to a roll over motor vehicle accident on xx/xx/xx. He continues to complain of pain with a VAS of 7. The pain is primarily in the lower left and lower right lumbar spine with radiation to the bilateral buttocks, bilateral hips, bilateral posterior thigh, anterior lower leg and feet. The pain is sharp and burning and severe. On 6/2/2008 Dr. notes the injured worker had no relief from bilateral L4 Transforaminal ESI. Physical exam shows normal DTR's and muscle strength with a positive bilateral Kemp sign. There is decreased ROM at the waist. Medications are Vicoprofen 7.5 mg. q 4 to 6 hours prn pain and Zanaflex 2 mg. 1 tid with food. MRI of the lumbar spine on 3/7/2008 shows at L4-5 mild disc desiccation and a focal posterior annular tear present on the left side with a 2 mm extraforaminal HNP. The requesting physician believes that because the injured worker has an annular tear at the L4-5 level it is the cause of pain in the facet joints and therefore there is a request for bilateral L4-S1 FMNB to help reduce the amount of pain.

The request has been previously denied because it does not meet ODG Guidelines for facet medial nerve block. The appeal upheld the initial determination.

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

Upon independent review of the provided medical records and ODG Guidelines and Treatment Guidelines, this reviewer finds that the requested ACS services are not medically necessary. I concur with the previous rationale that the injured worker does not meet ODG Guidelines for the requested service. There is evidence of radiculopathy and MRI shows focal herniation at L4-5 with annular tear. Under ODG Guidelines, the medial branch blocks are not supported with evidence of radiculopathy and in this case, the radiculopathy is supported by MRI findings.

#### **Criteria for use of therapeutic intra-articular and medial branch blocks, are as follows:**

1. No more than one therapeutic intra-articular block is recommended.
2. There should be no evidence of radicular pain, spinal stenosis, or previous fusion.
3. If successful (pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive).
4. No more than 2 joint levels may be blocked at any one time.
5. There should be evidence of a formal plan of additional evidence-based activity and exercise in addition to facet joint injection therapy.

**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)