

# Becket Systems Inc.

*An Independent Review Organization*

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**DATE OF REVIEW: FEBRUARY 7, 2009**

**IRO CASE #:**

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

Left lumbar medial branch block with fluoro

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

M.D., Board Certified in Physical Medicine and Rehabilitation

Board Certified in Pain Management

Board Certified in Electrodiagnostic Medicine

Residency Training PMR and Orthopaedic Surgery

## **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.

The reviewer finds that medical necessity does not exist for Left lumbar medial branch block with fluoro.

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

Adverse Determination Letters, 12/29/08, 1/8/09

MD, 12/19/08, 12/16/08, Letters of Medical Necessity

MRI of Lumbar Spine, 5/30/00

ODG Guidelines and Treatment Guidelines

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This is a xx year reportedly with low back pain. The MRI from xx/xx/xx showed a disc bulge at L4/5 and slight degenerative changes at the left L4/5 Facet. The physical examination of 12/16/08 described local tenderness over the bilateral facets, SI region, iliolumbar notch and pain prohibiting SLR. Most of the remaining material provided for this review relates to the cervical spine.

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

The medical records show the symptoms are bilateral. There is a comparatively minimal radiological finding from almost nine (9) years ago. According to the records, the patient's tenderness is generalized and not local. The request is for a medial branch block. This block can be justified for diagnostic purposes only according to the ODG. In this case, the diagnosis of facet pain has not been established. The patient does not meet the guidelines. The reviewer finds that medical necessity does not exist for Left lumbar medial branch block with fluoro.

**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)