

Wren Systems

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jul/24/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar Facet Block (64475, 77003)

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

M.D., Board Certified Orthopedic Surgeon

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

ODG Guidelines and Treatment Guidelines

Office notes, Dr., 10/20/08, 10/31/08, 11/14/08, 01/09/09, 03/11/09

Lumbar spine x-rays, 10/20/08

Office notes, Chiropractor, 10/20/08 to 01/27/09

Functional capacity assessment, 10/28/08

Office note, Dr., 12/10/08, 01/23/09

MRI lumbar spine, 12/22/08

AP and lateral views, lumbar spine, 12/22/08

MRI left knee, 02/09/09

X-rays left knee, 02/09/09

Computerized muscle testing, 02/27/09

Office note, Dr., 02/27/09, 06/09/09, 5/5/09, 2/27/09

Chest x-ray, 04/17/09

Operative report, Dr., 04/29/09

Prescription, 06/05/09

Computerized muscle testing, 06/09/09

Peer review, Dr., 06/17/09

Peer review, Dr., 06/24/09

PATIENT CLINICAL HISTORY SUMMARY

This is a xx-year-old male with complaints of low back pain. The lumbar x-rays of the spine showed no fracture, disc spaces well-maintained and slight retrolisthesis with the apex at L3. The MRI of the lumbar spine from 12/22/08 showed a transitional type vertebra at the lumbosacral junction designated as a partially sacralized L5 segment with rudimentary L5-S1 disc space, disc pathology was seen at the L4-5 level and no facet disease was seen at any level. The claimant saw Dr. for complaints of left knee and back. There were complaints of lumbar tenderness, decreased range of motion of the lumbar spine. Motor and sensation was intact. X-rays of the lumbar spine that day showed no fracture, subluxation or degenerative disc disease. Diagnosis was herniated nucleus pulposus L4-5 and anterior cruciate ligament tear left knee. Dr. recommended anterior cruciate ligament reconstruction. On 04/29/09, the claimant underwent anterior cruciate ligament reconstruction to the left knee. Dr. evaluated the claimant on 06/09/09. The claimant reported pain, denied radiation of pain and left knee pain. Positive Kemp was noted bilaterally. Painful and decreased range of motion of the lumbar spine was noted without neurological deficits. Diagnosis was axial back pain. Dr. requested lumbar facet medial branch blocks. The claimant has been treated with extensive chiropractic therapy, Darvocet, Ultram, Flexeril and off work.

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

The MRI in this case specifically did not reveal facet disease. There are no clear-cut facet findings. The reviewer is unable to recommend as medically necessary the proposed lumbar facet injections. The request does not conform to the ODG criteria for use of facet blocks. The reviewer finds that medical necessity does not exist for Lumbar Facet Block (64475, 77003).

Official Disability Guidelines Treatment in Workers' Comp 2009 Updates, chapter low back

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 (initial pain relief of 70%, plus 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-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)