

Notice of Independent Review Decision

DATE OF REVIEW: 11/12/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

64475 Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; lumbar or sacral, single level

64476 Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; lumbar or sacral, each additional level (List separately in addition to code for primary procedure)

QUALIFICATIONS OF THE REVIEWER:

This reviewer graduated from University of Texas Medical School and completed training in Anesthesiology/Pain Management at University of Texas Medical School. A physicians credentialing verification organization verified the state licenses, board certification and OIG records. This reviewer successfully completed Medical Reviews training by an independent medical review organization. This reviewer has been practicing Anesthesiology since 4/23/1993 and currently resides in TX.

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)

64475 Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; lumbar or sacral, single level Overturned

64476 Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; lumbar or sacral, each additional level (List separately in addition to code for primary procedure) Overturned

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Reviews of case assignment dated 10/23/2009
2. Request for a review by author unknown dated 10/21/2009
3. Fax page dated 10/21/2009
4. Request for a review by author unknown dated 10/21/2009
5. Pre authorization request by author unknown dated 10/21/2009
6. Notification of reconsideration by DO dated 10/20/2009
7. Fax page dated 10/12/2009
8. Pre authorization request by author unknown dated 10/12/2009
9. Letter by MD dated 10/12/2009
10. Notification of adverse determination by MD dated 10/09/2009
11. Pre authorization request by author unknown dated 10/06/2009
12. Outpatient visit by author unknown dated 06/18/2009 to 10/06/2009
13. Physical therapy service plan of care by author unknown dated 04/07/2009
14. MRI of lumbar spine by MD dated 03/30/2009
15. Daily note by author unknown dated 03/23/2009 and 03/26/2009
16. Physical therapy evaluation by author unknown dated 03/14/2009

Name: Patient_Name

17. IRO request form by author unknown dated unknown.
18. The ODG Guidelines were not provided

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

This is a female diagnosed with low back pain due to spondyloarthritis. The injured employee was seen in xx/xxxx and there was a prior ESI performed which reported a 60% improvement. The leg pain improved and there were continued complaints of low back pain. According to the outpatient visit with Dr. dated 10/06/2009, a 2nd ESI was performed with improvement in the leg pain but not the back. The injured employee states that it is an aching dull pain. She feels that her medication is not working as well as they had when she first began using them. The injured employee is to be evaluated for lumbar spondylarthritis. The location of pain is primarily in the lower and lower, right lumbar spine. It does not radiate. She characterizes it as constant, severe, dull, aching, and stabbing. She states that the current episode of pain started beginning in September 2009. There was a request for a diagnostic medical branch block on the right at L4-5 and L5-S1.

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

In this injured employee, there were 2 ESIs performed with resolution of the radicular pain. The injured employee had complaints of non radicular back pain. The ODG Guidelines support the use of diagnostic medial branch blocks in this situation. Therefore the services, right medial branch blocks, are medically necessary. The recommendation is to overturn the previous denial.

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)