

**SOUTHWEST MEDICAL EXAMINATION SERVICES, INC.**  
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Notice of Independent Review Decision

**DATE OF REVIEW:** October 21, 2009

**IRO CASE #:**

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

Bilateral lumbar medial branch block to include CPT code #76003, 64475, 64476.

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

Diplomate, American Board of Anesthesiology; Diplomate, American Academy of Pain Management

**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**

Medical records from the URA include:

Medical records from the Requestor/Provider include:

**PATIENT CLINICAL HISTORY:**

This is a male who sustained a work-related injury on xx/xx/xx, over xxxx years ago, while working. The patient was injured secondary to falling into a ditch. The patient reportedly was treated with facet blocks and percutaneous rhizotomy in addition to physical therapy back in 2003.

From the requesting providers, a recent followup note dated September 24, 2009 indicates the patient is complaining of pain in the low back with weakness and numbness radiating to both lower extremities.

A recently performed lumbar MRI from January 8, 2009 revealed L4-5 and L5-S1 central posterior disc herniation with multilevel neuroforaminal stenosis/spondylosis.

Plain x-rays performed on May 18, 2008 revealed L5-S1 spinal stenosis/spondylosis.

The submitted EMG/nerve conduction studies of the lower extremities performed on September 15, 2009, revealed mild-to-moderate peripheral neuropathy.

The submitted clinical examination of the lumbar spine revealed limited range of motion in all directions, bilateral paraspinal muscle tenderness over the facet joint areas, vertebral spine tenderness, bilateral sacroiliac joint tenderness, bilateral paralumbar myofascial trigger points, and tenderness over the bilateral intragluteal area. The straight leg raising test could not be performed secondary to pain. His gait was slow, and he needs assistance to arise from a chair. He was neurologically intact in the lower extremities.

Of note, the clinical findings on physical examination submitted by the requesting physician appear to be the same from the year 2008 and 2009, which makes it difficult to determine the patient's actual medical condition.

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

After a review of the information submitted, the previous non-authorization for bilateral lumbar medial branch nerve blocks has been upheld. The requesting provider has not determined medical necessity, in light of the clinical presentation, to proceed with the requested intervention in accordance with ODG Guidelines. These guidelines specifically indicate that the requested injections are limited to patients with low back pain that is non-radicular. In addition, the patient, based on the information available to the reviewer, does not have a reasonable suspicion for lumbar facet joint pain. The examination revealed multiple pain generator areas in the patient's lumbar spine. The submitted lumbar MRI did not reveal any facet joint hypertrophy or any other facet joint issues. There appears to be an extensive amount of lumbar myofascial pain identified in clinical examination. Finally, this injury is xxxx years old and a transition has already been made from the acute-to-chronic phase of pain.

The review outcome is upheld for previous non-authorization to perform bilateral lumbar medial branch nerve blocks.

#### **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)**