



Specialty Independent Review Organization
Notice of Independent Review Decision

DATE OF REVIEW: 8/4/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of lumbar facet blocks.

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

The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation. The reviewer has a second certification in Pain Management. This reviewer has been practicing for greater than 10 years and performs this type of service in his office.

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of lumbar facet blocks.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:
and, MD.

These records consist of the following (duplicate records are only listed from one source):
Records reviewed from Dr.: undated preauth form, 6/8/10 office note by Dr. and pg 1 of a lumbar MRI report from 3/2/10.

: 7/30/10 letter by, lumbar/thoracic ODG section (specifically facet joint injection section), 6/15/10 denial letter, 6/22/10 denial letter, 12/14/09 to 6/8/10 office notes by Dr., 3/2/10 MRI report (2 pgs), 12/8/08 medical analysis report and 12/4/08 review of medical records by MD.

A copy of the ODG was provided by the Carrier/URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient was injured during the course and scope of employment. He has undergone lumbar fusion at L4/5 and L5/S1 due to IV instability/spondylolisthesis. Next he underwent a hardware removal and currently has S1 radicular symptoms on the left side., MD documents a trial of lumbar facet injection with no relief on 2/4/10. A lumbar MRI on 3/2/10 reveals epidural scarring at L4/5 and L5/S1 and a L5 on S1 spondylolisthesis.

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

The ODG criteria for therapeutic intra-articular and medial branch blocks are as follows:

1. No more than one therapeutic intra-articular block is recommended. (this criterion is not met. The patient underwent injection prior to the 2/4/10 visit.)
2. There should be no evidence of radicular pain, spinal stenosis, or previous fusion. (this criterion is not met)
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). (this criterion is not met)
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. (there is no documentation provided that this criterion is met)

The records provided do not provide the documentation to show the above criteria have been met. Therefore, this procedure is not medically necessary at this time.

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 KNOWLEDGBASE
- 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)