

Prime 400 LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

May/17/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Bilateral Lumbar Medial Branch Block @ L4/5 L5/S1 Outpt 64490 64491

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

M.D., Board Certified in pain management and anesthesiology under the American Board of Anesthesiologists.

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

Adverse Determination Letters, 4/6/10, 4/20/10

M.D. 3/6/10

Rehabilitation Medicine and Pain Clinic 3/30/10, 2/18/10, 9/30/09, 9/23/09, 9/15/09, 9/10/09, 9/4/09, 9/3/09, 8/31/09, 8/27/09, 8/24/09, 4/7/10

PATIENT CLINICAL HISTORY SUMMARY

On xx/xx/xx, exam notes state this patient complains of pain in the lower back that worsens with extension and rotation in the spine. There are no "complaints to the lower extremities." There is tenderness noted over the lower lumbar region. A neurological exam performed on 3/6/10 showed a normal lumbar exam. The patient has failed PT and medication management. MRI of the lumbar spine did not show anything significant and showed "almost normal lumbosacral anatomy" per Dr. (DOS 3/6/10).

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

This patient's history and physical exam findings are consistent with the criteria for diagnostic medial branch blocks described by the ODG. There is no evidence of radicular pain, spinal stenosis or previous fusion. There is documentation of failure of conservative treatment. The request conforms to the ODG criteria. The reviewer finds that medical necessity exists for Bilateral Lumbar Medial Branch Block @ L4/5 L5/S1 Outpt 64490 64491.

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)