

MAXIMUS Federal Services, Inc.
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Notice of Independent Review Decision

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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: November 15, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient lumbar medial branch block, bilaterally at L3-4, L4-5 and L5-S1.

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

M.D., Board Certified in Orthopedic Surgery.

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 requested services, outpatient lumbar medial branch block, bilaterally at L3-4, L4-5 and L5-S1, are not medically necessary for treatment of the patient's medical condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization dated 10/21/10.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 10/22/10.
3. TDI Notice to IRO of Case Assignment dated 10/25/10.
4. EMG reports dated 4/16/10.
5. Radiology reports dated 2/20/07, 10/15/07, and 3/3/08.
6. Operative reports dated 11/27/07, 4/16/08, 5/1/08, 8/19/08,
7. Report from MD date not specified.
8. Records from DC, ATC dated 6/19/09, 11/6/09, 12/14/09, 1/19/10, 3/24/10, 5/4/10 and 5/6/10.
9. Records from Pain Consultants dated 6/3/10 and 6/17/10.
10. Records from Pain Management dated 8/10/10 and 9/8/10.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an on-the-job injury on xx/xx/xx. He was working as a xx and injured his back while opening a large heavy sliding gate. He is status post laminectomy and decompression in xx . The patient presented in April 2010 with persistent chronic intractable low back pain with pain radiating to the right lower extremity with paresthesias into the right foot. He has subjective weakness in the lower extremities. Physical examination on 8/10/10 showed evidence of positive straight leg raising bilaterally at 15 degrees. The patient had a normal EMG in April 2010. The provider recommended injections, specifically, outpatient lumbar medial branch block, bilaterally at L3-4, L4-5 and L5-S1. The Carrier has denied this request indicating that the requested service is not medically necessary for treatment of the patient's low back pain.

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

I have determined that the requested services, outpatient lumbar medial branch block, bilaterally at L3-4, L4-5 and L5-S1 are not medically necessary for this patient. The submitted documentation includes no evidence of MRI or myelogram with CT within the past two years. There is no evidence of advanced imaging since early 2008. Community standards require that the need for invasive procedures be supported by up-to-date diagnostic test results (advanced imaging). The Official Disability Guidelines (ODG) permits facet injections at two facet joint levels (three medial branch levels) if there is segmental rigidity. This patient has radicular symptoms and limited straight leg raising. There is no evidence of segmental rigidity. In this clinical setting, standard of care includes other interventions prior to facet blocks. In the absence of evidence of segmental rigidity, the medical necessity of the requested services is not established.

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)