

Notice of Independent Review Decision

DATE OF REVIEW: AUGUST 26, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical Necessity of Lumbosacral facet medical branch block at L4 and L5 (64493, 64494x2) and post injection PT 1x2 (97110 x3, 97140, 97112, G0283)

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

The physician performing this review is Board Certified, American Board of Anesthesiology with a specialty in Pain Management and Diplomate, National Board of Examiners. He is currently an Attending Pain Management Specialist at a University Hospital. He is a Member of the American Society of Anesthesiologists, Society for Education on Anesthesia, and International Anesthesia Research Society. He is licensed in the state of Texas and New York.

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

The request for LUMBOSACRAL FACET MEDIAL BRANCH BLOCK AT L4 AND L5 (64493, 64494, X2) should be certified as per official disability guidelines

The request for POST INJECTION PT 1x2 (9711 x3, 97140, 97112, G0283, is noncertified.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records Received: 23 page fax 8/19/2010 Texas Department of Insurance IRO request, 78 page fax 8/19/2010 from URA (Assignment by State, pre-auth request, pre-auth denial letter, pre-auth denial appeal, pre-auth denial appeal denial letter, IRO request submitted by carrier, IRO request sent to state by carrier)

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient has a history of low back pain. The pain is a 7 on a 0-10 scale. There is associated weakness in right leg and tingling. On physical exam there is tenderness in the L4-S1 facets with spasm and positive facet loading. The patient is on mobic and flexeril. He had treatment of ESI which did not help and physical therapy x18 sessions. An MRI shows disc bulge at L4-L5 with encroachment.

The DYLL REVIEW

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

The request for LUMBOSACRAL FACET MEDIAL BRANCH BLOCK AT L4 AND L5 (64493, 64494, X2) should be certified as per official disability guidelines below as it states the following "Criteria for the use of diagnostic blocks for facet "mediated" pain:

1. One set of diagnostic medial branch blocks is required with a response of $\geq 70\%$. The pain response should be approximately 2 hours for Lidocaine.
2. Limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally.
3. There is documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks.
4. No more than 2 facet joint levels are injected in one session (see above for medial branch block levels

This patient has evidence of facet syndrome on exam and has failed conservative therapy of medications and physical therapy. He meets the criteria for a diagnostic facet injection as per above criteria.

The second request for POST INFECTION PT 1X2 (97110X3, 97140, 97112, G0283.noncertified. There is no criteria that supports post-op facet injection physical therapy and therefore this is noncertified.

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)