

Notice of Independent Review Decision

DATE OF REVIEW: 9/7/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of medial branch blocks bilateral L4-5 (64493, 64494)

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 Physical Medicine & Rehabilitation. He is certified in pain management. He is a member of the Texas Medical Board. He has a private practice of Physical Medicine & Rehabilitation, Electrodiagnostic Medicine & Pain Management in Texas. He has published in medical journals. He is a member of his state and national medical societies.

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 denial of both the initial as well as reconsideration for medical branch block, bilateral, L4-5, is based on the ODG section for "Facet Joint Medial Branch Blocks, Diagnostics."

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records received; 16 page fax 8/24/2010, 35 page fax 8/25/2010

The information comes from medical records of, M.D., for dates of service June 3, 2010, June 30, 2010, July 20, 2010, July 30, 2010, and August 4, 2010. Additionally, medical report of, M.D., June 9, 2010, MRI, lumbar and thoracic, June 3, 2010, pre-authorization denial for initial request of service and for reconsideration request from Worker's Comp Services.

PATIENT CLINICAL HISTORY [SUMMARY]:

Medical information indicates that this injured worker was involved in a rollover-type motor vehicle accident with persisting pain in the lower back. This patient with treatment initially directed by the requesting provider consisted of two lumbar spine epidural steroid injections for which he was noted to have received positive response for a reasonable period of time. Further documentation of patient treatment in the form of

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medication use and any physical therapy or similar treatment is not objectively documented in the provided information. Both prior reviewers for the requested pre-authorization were in agreement of the documentation not meeting ODG criteria.

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

Based on review of the above documentation, in my medical opinion, the denial of both the initial denial and the reconsideration should be upheld.

As noted in both of the denial responses by the reviewers, the requestor of these services failed to document the necessary supporting agreement information with the ODG criteria for this to be considered medically reasonable and necessary.

Source of reference: ODG Criteria for The Use of Medical Branch Block, Diagnostic, in the Treatment of Suspected Facet Originating Pain in the Treatment of the Lumbar Spine.

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-- ODG Criteria for The Use of Medical Branch Block, Diagnostic, in the Treatment of Suspected Facet Originating Pain in the Treatment of the Lumbar Spine.
- 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)