



Professional Associates, P. O. Box 1238, Sanger, Texas 76266 Phone: 877-738-4391 Fax:
877-738-4395

Notice of Independent Review Decision

DATE OF REVIEW: 12/16/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Bilateral L4-L5 and L5-S1 facet medial branch blocks with fluoroscopy

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

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)

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.

Bilateral L4-L5 and L5-S1 facet medial branch blocks with fluoroscopy - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Evaluations with D.C. dated 03/09/09 and 09/17/10
A lumbar myelogram CT scan interpreted by M.D. dated 09/25/09
An EMG study interpreted by M.D. dated 01/26/10
A lumbar discogram CT scan interpreted by M.D. dated 04/20/10
Evaluations with M.D. dated 08/31/10, 09/30/10, 10/29/10, and 11/29/10
A letter of denial, according to the Official Disability Guidelines (ODG), from M.D. dated 09/24/10
A preauthorization request from Dr. dated 09/30/10
Letters of denial, according to the ODG, from dated 10/12/10 and 10/27/10
A letter of denial, according to the ODG, from D.O. dated 10/12/10
A letter of appeal for lumbar facet joint medial branch blocks from Dr. dated 10/21/10
A letter of denial, according to the ODG, from M.D. dated 10/27/10
The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY

On 03/09/09, Dr. recommended physical therapy three times a week for four weeks and off work status. A lumbar myelogram CT scan interpreted by Dr. on 09/25/09 showed disc degeneration most advanced at L5-S1, a 2-3 mm. diffuse disc protrusion, slight retrodisplacement of the underfilled left S1 root sleeve, bilateral flaval and facet joint hypertrophy at L5-S1, and a 2 mm. diffuse disc protrusion at L4-L5 with mild facet joint spurring. An EMG interpreted by Dr. on 01/26/10 showed denervation of the bilateral L5-S1 paraspinal muscles of a mild degree, which suggested involvement of the posterior nerve rami. A lumbar discogram CT scan interpreted by Dr. on 04/20/10 showed both the L4-L5 and L5-S1 discs were disrupted and caused severe concordant pain. On 08/31/10, Dr. refilled Flexeril, Lyrica, and Norco and recommended continued therapy and aerobic exercise. On 09/24/10, Dr. wrote a letter of non-certification for lumbar spine surgery. On 09/30/10, Dr. recommended bilateral L3-L5 median branch blocks and continued medications. On 10/12/10 and 10/27/10, wrote letters of denial for the bilateral L3-L5 median branch blocks. On 10/12/10, Dr. wrote a letter of non-certification for the injections. On 10/21/10, Dr. wrote a letter of appeal for the injections. On 11/29/10, Dr. refilled the medications and recommended continued therapy.

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

The requested bilateral L4-L5 and L5-S1 facet median branch blocks with fluoroscopy are neither reasonable nor necessary. The ODG endorses facet median branch blocks for diagnostic purposes only. The patient has had one set of median branch blocks with moderate response and repeating those at this time would not be appropriate. Therefore, the requested bilateral L4-L5 and L5-S1 facet median branch block would not be reasonable or necessary and the previous adverse determinations should be upheld.

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 AND KNOWLEDGE BASE
- 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)