

Notice of Independent Review Decision

PEER REVIEWER FINAL REPORT

DATE OF REVIEW: 2/7/2011
IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Medial Branch Nerve Block of the Left L3-S3

QUALIFICATIONS OF THE REVIEWER:

Physical Med & Rehab, Pain Management
MD

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)

Medial Branch Nerve Block of the Left L3-S3 Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Notice of assignment dated 1/18/2011
2. Notice to utilization review dated 1/18/2011
3. Request form by author unknown, dated 1/17/2011
4. IRO request form by author unknown, dated 1/17/2011
5. Letter by RN, dated 1/11/2011
6. Letter by RN, dated 12/27/2010
7. Request for pre-authorization by MD, dated 12/20/2010
8. Operative report by MD, dated 11/5/2010
9. Letter of intent by RNC, dated 10/7/2010
10. Progress note by MD, dated 9/30/2010 to 1/13/2011
11. Required medical examination by MD, dated 8/24/2010
12. Request for pre-authorization by MD, dated 1/3/2010
13. Clinical note by, dated unknown

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

The injured employee is a male with complaints of low back pain (LBP). Note on 1-13-11 reported 2-3 days of pain relief after a left SI joint injection. Injured employee is complaining of Left hip and leg pain. Discussion made regarding past surgical treatment consisting of lumbar fusion L2-S1, left sacroiliitis, and left Piriformis Syndrome. No exam findings given on that date. Note on 12-16-10 reported one day of pain benefit after the Left SI Joint Injection.

There was discussion of improved right lower back pain as well. Note on 11-18-10 reported significant benefit from a combined procedure consisting of Left SI Joint injection and Left Piriformis Injection. Exam reported positive Gaenslen's and Patrick's testing bilaterally left greater than right. There are no focal neurological deficits. There is no discussion regarding extent of past conservative treatment including PT/HEP in conjunction with medications. Procedure note on 11-5-10 reported Left SI Joint injection and left piriformis Injection each with corticosteroid.

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

Based upon the available documentation and the ODG Guidelines, I do not recommend the request for Medial Branch Nerve Block of L3-S3 to be reasonable or medically necessary. Recent past injection treatment has consisted of simultaneous left SI Joint and Left Piriformis injections with reported maximum of 3 days pain benefit after utilizing corticosteroids in the injections. There is no evidence supporting that the Left SI Joint in fact was the main pain reliever when 2 injections in the same region were performed on the same day. There are no measured functional gains or numerical description of pain relief specifically attributed to the Left SI Joint injection. The reasoning to perform confirmatory medial branch blocks is to proceed with RF procedure; however, RF procedures for the SI Joint are not supported by guidelines. Of further concern is the fact that maximization of conservative treatment with formalized PT and use of a daily HEP is not established in the recent treatment notes. The recommendation is to uphold the previous denial.

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)