

SENT VIA EMAIL OR FAX ON
Mar/04/2011

True Decisions Inc.

An Independent Review Organization
835 E. Lamar Blvd. #394
Arlington, TX 76011
Phone: (214) 717-4260
Fax: (214) 594-8608
Email: rm@truedecisions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Mar/04/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Right L3, L4, L5 Median Branch Block with Fluroscopy

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Board Certified in Physical Medicine and Rehabilitation
Subspecialty Board Certified in Pain Management
Subspecialty Board Certified in Electrodiagnostic Medicine
Residency Training PMR and ORTHOPAEDIC 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines
Letter from Dr. 1/28/11
Orthopedic Surgery Group 7/23/10 thru 12/15/10
Hospital 10/1/10 thru 11/18/10
1/18/11 and 2/8/11

PATIENT CLINICAL HISTORY SUMMARY

This is a man with a history of back pain and a work related injury on xx/xx/xx. He had an EMG in December that showed bilateral L5 radiculopathy. He has an MRI (8/24/10) that showed mild to moderate spinal stenosis at L3/4 to L5/S1. There were disc bulges at L1/2 to L5/S1 with facet arthritis and foraminal narrowing. He received transformainal ESIs at L4/5

and L5/S1 on 10/4/10 and at L2/3 and L3/4 on 11/18/10. Dr. felt these helped. He still had local pain in the lumbar paraspinal region with tenderness along the facet levels. He requested approval for right L3/4 and L4/5 medial facet blocks. These were previously denied as the pathology was not related to the work injury. Dr. wrote of the MRI changes in the facets, and the local tenderness. He felt the MBB will provide relief, and may lead to a radiofrequency rhizotomy.

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

Dr. noted that the disc degeneration preceded the onset of his current problem. (8/30), but felt the ESI was needed. The radiological findings are chronic and therefore, his structural problems were pre-existing. The IRO reviewer concurs. However, the IRO reviewer understands their role is not to determine if the problem is work related or not, but only address medical necessity. He generally meets the requirements for the presence of facet pain with a key exception. The ODG does not include radiculopathy. The ODG cites the conflicting opinions of the radiological findings and an association with facet pain. It will consider MBB in a diagnostic rather than therapeutic category. Dr. is using this for this purpose. He is considering the RF if necessary if there is adequate but transient relief. The concern is that the procedure is "Limited to patients with low-back pain that is non-radicular and at no more than two levels..."

He has radicular problems, but they appear to have improved. A single MBB (the two levels) would be justified if the problem has been deemed work related. That requires an administrative rather than a medical decision at this point.

There are no physician medical records prior to Dr. seeing him on 8/12. The IRO reviewer does not know who ordered the therapy in July. The IRO reviewer's medical assessment is that procedure has medical justification for a trial of pain control, but the pain is not work related. Dr. wrote on 12/15/10 "He had years of trouble with is back and his left leg, however, around June 26 he feels he may have aggravated his back and now is having severe right leg pain." As the IRO reviewer reads this, the back pain was preexisting, but the leg pain worsened. This justified the ESI for the radicular pain, but has not supported the back and facet pain as being work related from this injury. However, since and IRO reviewer can only address medical necessity, the request is medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICA 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)