

Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 12/19/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Appeal ODG lumbosacral MBB 64493 64494 64495 11040 J3490 72020

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

The TMF physician reviewer is board certified in pain management with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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.

It is determined that the ODG lumbosacral MBB 64493 64494 64495 11040 J3490 72020 is not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 12/13/11
- Determination letter – 10/28/11, 12/06/11

- Letter to – 12/14/11
- Report of MRI of the lumbar spine – 08/03/11
- Report of toxicology – 06/30/11
- Office visit notes from Dr. – 11/11/10 to 08/18/11
- Office visit notes from Dr. – 11/15/10 to 10/03/11
- Procedure notes by Dr. – 05/11/11
- Office visit notes by Dr. – 06/28/11
- Physical therapy initial evaluation – 06/09/11
- Physical therapy notes – 06/09/11 to 06/20/11
- Physical therapy Re-evaluation /Discharge – 08/23/11
- Spinal Clinic Neck Pain Questionnaire – 08/23/11
- Copy of ODG Integrated Treatment/Disability Duration Guidelines, Low Back – Lumbar & Thoracic (Acute & Chronic) – 12/13/11

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx/xx/xx that resulted in cervical neck pain and low back pain. He has been treated with medications, physical therapy treatments and epidural steroid injections. An MRI of 08/03/11 indicates a shallow disc protrusion at L4-5. He continues to complain of neck pain radiating to the back of his head with numbness in the left hand. He also complains of low back pain radiating to the lower extremities. There is a recommendation for lumbosacral medial branch blocks.

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

The injury was sustained in xxxx. Multiple treatment modalities utilized. There is pain/tenderness over lumbar facets, worse with loading the facets. It would be reasonable to perform MBB if Dr. would fill in the information needed to fulfill ODG, but there is inadequate data presented to meet ODG: levels not specified, complete physical examination (neurological) not performed, no documentation of failure of conservative measures.

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)