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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Oct/24/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Bilateral L2-L4 Medial Branch Block CPT 64493x2, 64494x2, 77003, 99144

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

M.D., Board Certified Anesthesiology; Board Certified Pain Management

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 medical necessity exists for each health care service in dispute. The reviewer finds medical necessity is not established for Bilateral L2-L4 Medial Branch Block CPT 64493x2, 64494x2, 77003, 99144.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

CT of the lumbar spine dated 11/29/05

Clinical notes dated 12/15/10 – 08/30/12

Prior reviews dated 09/07/12 and 09/25/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who has been followed for chronic low back pain following a lumbar fusion from L3-S1. CT studies of the lumbar spine completed in 11/05 revealed intact hardware and solid lumbar fusion from L3-S1. The patient was treated for chronic pain with narcotic medications to include Norco and Hydrocodone. The patient had pain management referrals in 05/12 as well as surgical consultation regarding the patient's L2-3 level. Clinical evaluation on 08/30/12 reported continuing low back pain that was sharp and constant. Physical examination revealed tenderness to palpation over the bilateral paravertebral musculature and facet joints from L2-5. There is reproduction of pain with facet loading. The patient was recommended for medial branch blocks. The request for medial branch blocks from L2-4 was denied by utilization review on 09/07/12 as it was unclear what other conservative treatment the patient had failed prior to recommendation for medial branch blocks. It was unclear whether the medial branch blocks were being performed for diagnostic purposes. The request was again denied by utilization review as the recommended blocks would occur at levels that were previously fused and are contraindicated by current evidence based guidelines.

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

This patient has undergone prior lumbar fusion from L3-S1. The patient continued to report chronic low back pain and there are objective findings of facet mediated pain on exam. With the request for medial branch blocks from L2-4, this would involve levels that have been previously fused and current evidence based guidelines do not recommend the use of medial branch blocks at previously fused levels. The clinical documentation does not indicate whether these injections will be used as a diagnostic tool or are therapeutic in nature. There is also no indication that the patient would continue an evidence-based exercise program or physical therapy following the requested injections.

As the clinical documentation provided for review does not meet guideline recommendations for the request, the reviewer finds medical necessity is not established for Bilateral L2-L4 Medial Branch Block CPT 64493x2, 64494x2, 77003, 99144.

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)