



ALLMED REVIEW SERVICES INC

ktomsic@allmedreview.com

627 Russell Blvd.

Nacogdoches, TX 75965

936-205-5966 office

(214)802-2150 cell

(888) 272-0749 toll free

(936)205-5967 fax

Notice of Independent Review Decision

Date notice sent to all parties: 10/11/13

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L3-4 medial branch block

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

Texas Licensed Board Certified Orthopedic Surgeon

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 of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

1. Notice of IRO Assignment
2. LHL009
3. 7/24/13 and 8/29/13 Denial Letters
4. 7/19/13 Pre-authorization Request Form
5. 8/19/13, 7/18/13, 7/16/13, 4/17/13, 2/22/13, 1/22/13 notes
6. 6/5/12 MRI L spine with and without contrast
7. 7/23/13 and 8/26/13 Peer Review Reports
8. 8/21/13 Pre-authorization Request Form
9. 4/24/12 CT Lumbar Spine WO

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant has been injured in xx/xxxx. The claimant has been treated for ongoing low back pain. More recently, the claimant has history of having being treated with L3-L4 facet blocks on 03/14/2013. Provided records reveal that there was 100% relief for a three-day period with progressive symptomatic return as of 07/16/2013. The lumbar pain was noted to have returned and to be constant. The claimant who reportedly continue to work on a full-time basis maintained a semi-kyphotic position while sitting in the exam room. When standing from a seated position, the claimant had increased pain. Flexion decreased the pain. There were no focal neurologic findings. The claimant was noted to have retained hardware from a prior fusion, which was noted to be in "great location and intact" as noted on 07/16/2013. The impression included that of back pain, facetogenic pain, facet gapping, and lumbar herniated disc. The consideration was for a followup injection. The prior records were also reviewed including a lumbar MRI dated 08/05/2012, which revealed status post "laminectomy with interbody fusion, grafting, lateral plate, and rod and pedicle screw fixation with wide patency to the canal and foramina and enhancing and circling epidural fibrosis."

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

The claimant has not had guideline associated considerations or criteria met for a repeat injection. A repeat injection, i.e. a therapeutic injection is typically only considered optimal or appropriate if there is at least 50% pain relief for a six-week period. This did not at all occur after the prior facet injection treatment. The claimant therefore at this time does not have an indication for a repeat injection based on the response from the prior injection. The opinion is to uphold denials. Guidelines are ODG, low back regarding medial branch block/facet injection.

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)**