

US Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/12/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: MBB injection @ R L4-S1

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Physical Medicine and Rehabilitation and Pain Medicine

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. It is the opinion of the reviewer that the request for MBB injection @ R L4-S1 is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Utilization review determination dated 06/28/13, 06/18/13
MRI right knee dated 03/15/13
Radiographic report dated 03/15/13
Office note dated 04/15/13, 05/15/13, 05/22/13, 06/24/13
MRI lumbar spine dated 06/07/13
Handwritten note dated 06/12/13, 05/27/13, 03/20/13, 07/10/13, 03/06/13
Teleconference note dated 06/24/13, 06/18/13
Initial evaluation dated 03/06/13
Progress note dated 04/01/13, 04/09/13, 04/11/13, 04/12/13, 04/17/13
Addendum dated 04/24/13
Recheck dated 04/24/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male whose date of injury is xx/xx/xx. On this date the patient was standing in deep mud when he turned and tripped with a resultant hyperextension injury to his right knee. The patient then fell backwards injuring his low and mid back area. The patient participated in a course of physical therapy. MRI of the lumbar spine dated 06/07/13 revealed mild disc space narrowing and desiccation are present at several levels, but there are no posterior disc bulges. No spinal stenosis or foraminal stenosis are present. Mild degenerative facet arthrosis is seen at L4-5 and L5-S1 without mass effect. Handwritten note dated 07/10/13 indicates that the patient complains of persistent low back pain and into the right leg. Right knee pain persists. On physical examination there is absent reflex at the right knee. Straight leg raising is positive on the right.

Initial request for MBB injection at right L4-S1 was non-certified on 06/18/13 noting that the

records submitted for review contain subjective findings of radicular low back pain with a positive straight leg raise test on physical examination. Clinical records submitted also do not indicate any suggestion of a subsequent neurotomy after the injection deeming the procedure inappropriate at this time. The denial was upheld on appeal noting that physical examination did indicate a positive straight leg raising test for the patient on the right which would not support facet mediated pain. The patient also continued to complain of subjective low back pain that radiated to the right thigh. The provider also stated that the patient was documented to have pain upon extension that was facet type leg pain. However, the clinical evidence submitted continues to fail to identify progression to radiofrequency neurotomy if the medial branch is positive.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient's physical examination documents positive straight leg raising on the right as well as absent reflex at the right knee. The patient complains of low back pain radiating to the right lower extremity. The Official Disability Guidelines note that medial branch blocks are limited to patients with low back pain that is non-radicular in nature. Additionally, there is no documentation in the submitted records that if the medial branch block is positive the patient will be recommended to undergo radiofrequency neurotomy. As such, it is the opinion of the reviewer that the request for MBB injection @ R L4-S1 is not recommended as 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 KNOWLEDGBASE

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)