

US Decisions Inc.

An Independent Review Organization
1201 Spyglass Drive Suite 100
Austin, TX 78746
Phone: (512) 782-4560
Fax: (207) 470-1085
Email: manager@us-decisions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jan/28/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with imaging guidance (fluoroscopy or CT), lumbar or sacral; single level

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M. D. Board Certified Anesthesiology/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. It is the opinion of the reviewer that medical necessity is not established for Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with imaging guidance (fluoroscopy or CT), lumbar or sacral; single level.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
CT lumbar spine dated 11/19/05
Clinical notes dated 12/15/10 – 12/12/12
Prior reviews dated 09/07/12 – 01/02/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who sustained an injury on xx/xx/xx. The patient is status post lumbar fusion from L3-S1 per the CT of the lumbar spine completed in 11/05. The patient has been followed for chronic low back pain radiating through the right lower extremity. Clinical evaluation on 05/22/12 stated that the patient was stable with the use of Norco. Physical examination revealed tenderness to palpation above the level of lumbar fusion and there is decreased range of motion of the lumbar spine. Reflexes in the lower extremities were decreased on the right as compared to the left. The patient was referred for a pain management consult regarding narcotics usage. The patient was also recommended to continue with a home exercise program. Pain management evaluation dated 08/30/12 stated that the patient has had continued ongoing low back pain as well as thoracic pain which has been increasing recently. Physical examination revealed tenderness to palpation in the lumbar paravertebral musculature and facet joints from L2-5. There was reproduction of pain with facet loading. The patient was recommended for medial branch blocks above the level of the prior fusion. Follow-up on 12/12/12 stated that the patient's symptoms are unchanged. Physical examination revealed tenderness to palpation over the paravertebral musculature of the facet joints from T12-L5 with positive facet loading.

The patient was recommended for lumbar medial branch block at L1, L2, and L3.

The requested lumbar medial branch blocks from L1-3 was denied by utilization review on 12/17/12 as it was unclear how this treatment would be helpful for the patient's overall treatment plan. Also, medial branch blocks are contraindicated when lumbar fusion has occurred.

The request was again denied by utilization review on 01/02/13 as there was no documentation that the patient met requirements as outlined by guidelines to include lack of evidence regarding radiculopathy and as there was prior fusion at the requested levels.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: Based on the clinical documentation provided for review, the patient is status post lumbar fusion from L3-S1. Per guideline recommendations, medial branch blocks at L3 would be contraindicated. Although there is no recent evidence of lumbar radiculopathy, it is unclear at this point in time how lumbar medial branch blocks would help in the patient's treatment of chronic low back pain. There is no indication in the clinical documentation that the patient would continue with further treatment if positive medial branch blocks were present. Given the presence of lumbar fusion at L3 which contraindicates the injections and given that there is no indication of how the medial branch blocks would improve the patient's severe chronic low back pain, it is the opinion of the reviewer that medical necessity is not established for Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with imaging guidance (fluoroscopy or CT), lumbar or sacral; single level and the prior denials are upheld.

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)