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Notice of Independent Review Decision

DATE NOTICE SENT TO ALL PARTIES: 8/13/15

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of lumbar facet blocks L5/S1, L4/L5 bilaterally medial branch block of the dorsal ramus, 64494 inj paravert f jnt L/S 2 lev, 77003 fluoroguide for spine inject, 01992 anes-dx/tx nrv blks & inj;pront pstn, J3301 inj triamcinolone acetoneide 10 mg, and J2250 injection midazolam HCL per 1 mg.

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

The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation. The reviewer has been practicing for greater than 10 years.

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of lumbar facet blocks L5/S1, L4/L5 bilaterally medial branch block of the dorsal ramus, 64494 inj paravert f jnt L/S 2 lev, 77003 fluoroguide for spine inject, 01992 anes-dx/tx nrv blks & inj;pront pstn, J3301 inj triamcinolone acetoneide 10 mg, and J2250 injection midazolam HCL per 1 mg.

PATIENT CLINICAL HISTORY [SUMMARY]:

This claimant has a date of birth of xx/xx/xx. He reported an injury xx/xx/xx. He reports lifting a 25-30 pound x and feeling a sharp pain in the low back radiating to the left hip. He now reports radiation to both legs. He continues to work full duty. MRI shows L4/5 and L5/S1 disc bulges with neuroforaminal narrowing. A note from 6/4/2015 indicates he had an ESI and there was no improvement in his pain levels. Notes indicate that he has used Neurontin.

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

This claimant has had a medical branch block. The notes indicate there was no improvement in pain. Therefore an additional block is not indicated. There is no evidence of involvement of the facets based on the physical examination. The claimant's symptoms and imaging studies are consistent with a degenerative process and there is no indication for facet injection. Therefore, the requested procedures are not medically necessary at this time.

The guidelines do recommend ESI as a possible option for short term treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) with use in conjunction with active rehab efforts. Radiculopathy symptoms are generally due to herniated nucleus pulposus or spinal stenosis although ESIs have not been found to be as beneficial a treatment for the latter condition. The criteria include that 1. Radiculopathy must be documented objectively. 2. Condition should be initially unresponsive to conservative treatment. 3. A repeat block is not recommended if there is inadequate response to the first block. The criteria for facet joint blocks are tenderness to palpation over the facets with a normal sensory examination and absence of radicular findings although pain may radiate below the knee and normal straight leg raising.

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)