

Vanguard MedReview, Inc.

101 Ranch Hand Lane

Aledo, TX 76008

P 817-751-1632

F 817-632-2619

April 20, 2018 amended May 4, 2018

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

1 Bilateral L5/S1 Medial Branch Facet Block under Fluoroscopy with Anesthesia between XXXX.

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

Management with over 12 years of experience.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

XXXX: Office Visit by XXXX. **HPI:** The patient presents today with new injury to back and right shoulder. XXXX was in a XXXX and has been taking XX and XX. XXXX states they help XXXX shoulder, but not XXXX back pain. Pain 5/10. XXXX is a general foreman at XXXX job. **Physical Exam:** Tenderness in the anterior right shoulder. Full ROM. Rotator cuff test: negative drop arm test, negative empty can test and negative lift off test. Thoracic spine: Appearance is normal. Tenderness in the level T11-12 thoracic spine. Palpates normal, full ROM. Flexion painful. Extension painful. Left rotation painless. Right rotation painless. **Assessment:** 1 Strain of thoracic region. 2. Strain of shoulder, right. **Plan:** 1. Hot/cold compress. 2. X-ray, right shoulder. 3. X-Ray, spine, thoracic, 2 views.

XXXX: XX Office Visit by XXXX. **Physical Exam:** Thoracic spine: Tenderness in the level T8-12 thoracic spine. Lumbosacral spine: Level L5-S1 lumbar spine tenderness present. Left thoracolumbar side bending painful. Right Thoracolumbar side bending painful. Left Thoracolumbar rotation painful. Right thoracolumbar rotation painful. **Assessment:** 1. Strain of the thoracic region. 2. Lumbar strain. **Plan:** 1. Start XX. 2. Start XX. 3. Physical Therapy.

XXXX: Office Visit by XXXX. **HPI:** XXXX has completed 6 sessions of PT and is improving. XXXX noted a decrease in pain and increase in ROM. Roughly 50% of anticipated healing has taken place. **Plan:** Renew meds, continue PT.

XXXX: Office Visit by XXXX. **HPI:** Pain is 5/10. Pain meds are helping and XXXX is continuing PT. XXXX continues to improve. Pain comes and goes and is no longer constant. Roughly 75% of anticipated healing has taken place.

XXXX: Office Visit by XXXX. **HPI:** Patient presents for recheck. XXXX reports occasional numbness and tingling down XXXX leg. XXXX has met all XXXX goals in therapy, but XXXX continues to report pain. **Physical Exam:** Thoracic spine: No tenderness. Full ROM. All bending painless. Lumbosacral spine: Full ROM. Normal motor tone. **Assessment:** 1. Strain of the thoracic region. 2. Lumbar strain. **Plan:** MRI, spinal canal and contents, lumbar, without contrast.

XXXX: MRI Lumbar Spine interpreted by XXXX. **Impression:** 1. Mild to moderate left foraminal stenosis at L4-5 secondary to leftward disc protrusion or sub ligamentous disc herniation measuring approximately 5mm. 2. Posterior disc protrusion or sub ligamentous disc herniation measuring approximately 4mm at L5-S1 contained within the epidural fat without stenosis.

XXXX: Consultation by XXXX. **HPI:** MRI of the thoracic spine was denied. MRI of the spine shows herniated disc. Complaining of low back pain at this time that does not radiate. XXXX is working full duty. Pain is worse by bending, twisting, lifting, and standing for long periods. Decreased with lying down. XXXX has been taking meds and PT without any significant help, still complaining of pain. XXXX states there is no significant weakness, numbness or tingling in the lower extremities. **Physical Exam:** Moderately obese. Flexion, extension, and rotation of the lumbar spine produces pain in the low back. XXXX has negative straight leg raise bilaterally. XXXX has spasms and pain in the bilateral L5-S1 facet area. XXXX also has spasms and pain in the bilateral paravertebral areas of the thoracic T6-7, T7-8. **Assessment:** Lumbar sprain/strain and thoracic sprain/strain. We will request bilateral L5-S1 medial branch facet blocks. If these are successful, PT with radiofrequency ablation. We would also concur with the request for MRI of the thoracic spine in spine of being denied in the past. Follow up 3 weeks.

XXXX: Medical Opinion Review performed by XXXX. **Rationale for Denial:** Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines revered above, this request is non-certified. Per evidence-based guidelines, magnetic resonance imaging of the thoracic spine is recommended for patients with thoracic spine trauma and neurological deficit. In this case, there was no objective evidence of neurological deficit from medical reports dated XXXX to justify the need for the diagnostic workup. Thus, the request is not supported at this time.

XXXX: UR performed by XXXX. **Rationale for Denial:** Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced below, this request is non-certified. There was an insufficient documentation of significant objective clinical findings suggestive of facet joint symptoms pertinent to the L5-S1 level that would warrant the need for this intervention. Furthermore, there was still no clear evidence that the patient had failed with conservative modalities (including home exercise, PT, and XX) for the lumbar spine prior to the procedure for at least 4-6 weeks as there were limited medical reports submitted to determine patient's prior treatments received to date and to objectively determine patient's functional response to the prior treatments received. Thus, the request is not supported.

XXXX: UR performed by XXXX. **Rationale for Denial:** Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced below, this request below, this request is not medically necessary. In light of this presenting issues and in the absence of pertinent extenuating circumstances that would require deviation from the guidelines, the appeal request for 1 Bilateral L5/S1 Medial branch Facet Block under Fluoroscopy with Anesthesia is not medically necessary as there was an insufficient documentation of significant objective clinical findings suggestive of facet joint symptoms pertinent to the L5-X1 levels that would warrant the need for this intervention.

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

Based on the records submitted and peer-reviewed guidelines, this request is non-certified. There is insufficient documentation of objective clinical findings suggestive of facet joint symptoms pertinent to the L5-S1 level that would warrant the need for this intervention. Additionally, there is still no clear evidence that the patient had failed with conservative modalities (including home exercise, PT, and NSAIDs) for the lumbar spine prior to the procedure for at least 4-6 weeks. Thus, the request is not supported.

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)**