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Notice of Independent Medical Review Decision
Reviewer's Report

DATE OF REVIEW: 5/1/18

IRO CASE #: XXXXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar facet block L4-5, L3-4 left side first day, right side second day, 64493 x 2, 64494 x 2, 99152 x 2.

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

M.D., Board Certified in Physical Medicine & Rehabilitation with sub-specialty certification in 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)

I have determined that the requested lumbar facet block L4-5, L3-4 left side first day, right side second day, 64493 x 2, 64494 x 2, 99152 x 2 are not medically necessary for the treatment of the patient's medical condition.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a XX with a history of an occupational claim from XXXX. On XXXX, magnetic resonance imaging (MRI) revealed postsurgical changes at L5-S1 level with laminectomy. There was demonstrable granulation tissue posterior to the thecal sac with no significant ventral or lateral epidural scar formation. There was neural foraminal narrowing that was moderate on the right at L5-S1 and bilateral L4-5 and left L5-S1. The office visit of XXXX revealed the patient had low back pain that was burning, intolerable, shooting, and there was associated numbness, weakness and muscle tenderness. The patient's current pain medications were working. The provider noted the procedure was denied as the patient had documented radicular pain and dermatomal deficits which were managed by the spinal cord stimulator. The patient had axial back pain which was interfering with XX ability to perform activities and XX quality of life. The physical examination revealed tenderness in the lumbar facet joints at L1-2, L2-3, L3-4, L4-5 and L5-S1. The patient was unable to perform heel walking or toe walking. The patient had

dermatomal deficits at L5, S1. The patient had axial facet pain palpated over the lumbar spine greatest at L3-4 and L4-5 facets. There was no radicular pain elicited from these areas on the visit. A requested has been submitted for lumbar facet blocks at L4-5, L3-4 left side first day, right side second day, 64493 × 2, 64494 × 2, and 99152 × 2.

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

The Official Disability Guidelines indicate that facet joint intra-articular injections (therapeutic blocks) are under study. The guidelines indicate that for a therapeutic intra-articular and medial branch block, there should be no more than one therapeutic block and there should be no evidence of radicular pain, spinal stenosis or previous fusion. If successful, with an initial pain relief of 70% plus relief at least 50% for duration of six weeks, the recommendation is to proceed to medial branch diagnostic block and subsequent neurotomy, if the block is positive. No more than two joint levels should be blocked at any one time, and there should be evidence of a formal plan of additional evidence-based activity and exercise in addition to facet joint injection therapy. In this case, the provider indicated the patient's radicular pain was taken care of by a spinal cord stimulator, and dermatomal deficits remained at L5-S1. Treatment is not recommended for radicular pain. There was a lack of documentation indicating the patient would be undergoing a formal plan of evidence-based activity and exercise in addition to the injection therapy. There were no exceptional factors noted. Thus, the requested services are not medically necessary per Official Disability Guidelines.

Therefore, I have determined the requested lumbar facet block L4-5, L3-4 left side first day, right side second day, 64493 x 2, 64494 x 2, 99152 x 2 are not medically necessary for treatment of the patient's medical condition.

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 JUDGMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

Official Disability Guidelines & Treatment Guidelines, 16th Edition (Web), 2018. Low Back Chapter, Facet Joint Intra-articular Injections (Therapeutic Blocks).

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)