Medical Assessments, Inc.

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April 3, 2019

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
XX facet block XX/XX medial branch block XX XX XX side

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The Reviewer is Board Certified in the area of Anesthesiology with over 10 years of experience, including Pain Management

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]:
The claimant is a XX-year-old who sustained an injury on XX while XX XX into an XX XX. The claimant was diagnosed with XX of XX of XX XX, initial encounter.

XX: MRI of the XX XX interpreted by XX. Impression: Mild XX XX XX XX greater than XX at XX-XX. There was minimal XX XX without XX at XX-XX through XX-XX.

XX: Office visit by XX. Claimant complained of XX XX that radiated into the XX XX XX. The claimant was able to stand, sit and walk for less than XX minutes. The pain level was currently 4/10 with 8/10 at its worse and 4/10 at its best. The claimant described the pain as tingling, throbbing, burning and numbness. The claimant reported nothing helped. The deep tendon reflexes were in intact in the XX XX. The straight XX raise was negative XX. There was facet pain on XX rotation, extension, flexion and palpation and axial loading in the XX XX. There was pain in the XX facets on the XX at the XX-XX.

XX: UR performed by XX. Rationale for denial: Per notes provided for review, the claimant had done PT, however there was limited evidence if the claimant had failed from the other lower levels of care such as NSAIDS,

muscle relaxants and XX drugs prior to considering the requested injections as there were limited medical records provided. As the requested surgical procedure is not medically necessary. Therefore, the requested XX facet block XX-XX medial branch block XX XX XX side is not medically necessary.

XX: Office visit by XX. Claimant reported pain level as 7-8/10 at its worse and 4/10 at its best. The claimant described the pain as tingling, throbbing, burning and numbness. The claimant reported nothing helped. On review of the systems, there was no changes since the most recent visit. There were no significant changes in the PE since the last office visit. XX visits of PT as of XX and use of heat. The claimant received XX ESI on XX with improvement in overall pain less than a 50%. The radicular pain was better. Current medications: XX and XX. The claimant had a degree of XX about XX.

XX: UR performed by XX. Rationale for denial: The use of IV sedation may be grounds to negate the results of a diagnostic block and should only be given in case of extreme XX. XX regarding XX does not justify excessive sedation for diagnostic facet blocks. Therefore, the requested XX facet block XX-XX medial branch block XX XX XX side is not medically necessary.

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. Per notes provided for review, the claimant had done XX therapy, however there was limited evidence if the claimant had failed from the other lower levels of care such as NSAIDS, muscle relaxants and XX drugs prior to considering the requested injections as there were limited medical records provided. As the requested surgical procedure is not medically necessary. The use of IV sedation may be grounds to negate the results of a diagnostic block and should only be given in case of extreme XX. XX regarding XX does not justify excessive sedation for diagnostic facet blocks. Therefore, the requested XX facet block XX-XX medial branch block XX XX XX side is not medically necessary.

Therefore, the request for XX facet block XX/XX medial branch block XX XX XX side is non-certified.

ODG Guidelines:

XX

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 XX 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)**