Medical Assessments, Inc.

4833 Thistledown Dr.

Fort Worth, TX 76137

P: 817-751-0545

F: 817-632-9684

January 2, 2019

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

XX XX block XX level medial branch of the XX ramus XX x1

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

The Reviewer is a Board-Certified Orthopedic Surgeon with over 15 years of experience. XXXX is fellowship trained in adult spine surgery

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.

XXXX: Office visit by XXXX. X-rays of the XX spine showed XX process fracture at XX which was also seen on the CAT scan. The AP and lateral views of the XX XX showed the XX fracture of the XX as well as XX process fracture on the XXXX in the XX XX region. The vertebrae were all aligned. There was no evidence of vertebral body collapse or loss of XX body height either in the XX or XX spine.

XXXX: MRI of the XX XX W/O contrast interpreted by XXXX. Showed normal XX XX cord and normal preservation of XX height and disc height throughout the XX column. There was no evidence of focal disc XX XX XX or foraminal XX. The posterior elements were intact. Also showed at XX, there was no disc XX or XX arthropahy. The central XX and XX were normal.

XXXX: MRI of the brain W/O interpreted by XXXX. Showed no intracranial abnormalities.

XXXX: Electroencephaloram report by XXXX. Showed normal findings.

XXXX: XXXX report by XXXX. Showed normal findings.

XXXX: Videonystagmography by XXXX. Showed that there were no clear central abnormalities noted in this test. Peripheral abnormalities were not clearly seen on this test except for a XX XX maneuver.

XXXX: History and Physical Report by XXXX. The claimant received XX facet at the XX medial branch block XX level.

XXXX: Office visit by XXXX. The claimant had improvement in overall pain by XX% and XX% after the procedure. XXXX was able to stand, sit and walk longer and sleep better. There was a decrease in pain medicine.

XXXX: Office visit by XXXX. The claimant complained of XX XX pain. XXXX had an improvement in overall pain by XX% after the procedure of XX medial branch XX blocks at XX. XXXX was able to stand for more than 30 minutes and able to sit for more than 30 minutes. XXXX was also able to walk for more than XX minutes with pain. The pain level was XX/10, worst and best at XX/10. The pain felt more like stabbing and burning that would come and go. On examination there was XX pain on XX facet XX at XX. There were medications taken in this visit. Prior treatment included medications, XX XX orthosis brace, PT and XX block.

XXXX: UR performed by XXXX. Rationale for denial: The claimant is a XXXX who was injured on XXXX. Based on the clinical information submitted for this review and using the evidence-based peer-reviewed guidelines, this request is non-certified. Per evidence-based guidelines, facet joint medial branch blocks is not recommended except as diagnostic too and has minimal evidence for treatment. In this case, the claimant underwent a XX medial branch block on XXXX with an overall improvement of pain by XX% after the procedure. Guidelines further state that one set of diagnostic medial branch blocks is required when facet neurotomy at the diagnosed levels is anticipated in the plan of care. A clear rationale for the second medial branch block must be documented. Exception factors were not identified.

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, this request if non-certified. The duration of pain of at least XX weeks was not addressed to support this request. There was also no measurable or quantifiable assessment for deep tendon reflexes, motor and sensory to objectively validate the absence of XX findings in a XX distribution. Furthermore, there should be evidence of a formal plan of additional evidence-based activity and exercise in addition to the XX joint injection therapy.

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

The request for XX XX XX block is denied.

This patient sustained a XX injury on XXXX. A XX process fracture at XX was identified following the XX accident. XXXX continues to have XX XX pain. A recent XX XX MRI documented mild disc XX and disc XX at XX, with mild XX XX. The XX level was unremarkable on MRI. XXXX completed a medial branch XX block at XX, which gave XXXX XX% pain relief. The treating provider has recommended an additional XX block at this level.

The Official Disability Guidelines (ODG) supports XX blocks for patients who have XX "mediated" XX pain without XX.

This patient's MRI points toward XX as the primary source of pain. Further treatment should be directed at this level. XXXX has no pathology at XX, which would require an invasive procedure at this level. The requested block is not medically necessary.

The requested XX facet block XX level medial branch of the XX ramus XX x1 is found to be not medically necessary.

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 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)**