MAXIMUS Federal Services, Inc.
807 S. Jackson Rd., Suite B
Pharr, TX 78577
Tel: 956-588-2900 ◆ Fax: 1-877-380-6702

Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: 03/11/19

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Authorization and coverage for XX XX-XX, XX-XX, XX-XX XX medial branch block.

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

M.D., Board Certified in Anesthesiology and Pain Medicine/Management.

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 is not medically necessary for the treatment of the patient's medical condition.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is an injured worker with a date of injury of XX. The injured worker presents with XX XX pain with XX sided XX pain. He has attended XX therapy and had epidural steroid injection with little relief. Exam reveals tenderness to palpation XX XX XX muscles, tenderness over facet joint area, XX XX tenderness, marked XX XX tenderness, tenderness along posterior aspect of XX XX extremity, decreased and painful range of motion (ROM), and decreased sensation to XX extremity.

XX XX MRI shows XX-XX no disc bulge, XX-XX XX mm disc XX impinging on the nerve root, XX-XX XX mm disc protrusion impinging XX nerve root. There is no facet hypertrophy documented on the MRI.

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

The patient has complaints of XX XX pain with XX radicular XX pain. The request is for a XX XX-XX median branch block, which is typically for XX XX pain. First, it is the wrong side of XX pain and XX pain complaint than the procedure requested. Second, the patient has radicular pain, which is a relative contraindication for XX facet procedures. Third, the provider is requesting XX levels when ODG states no more than XX levels are injected in XX session.

Therefore**,** I have determined the requested is 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 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)**