

Parker Healthcare Management Organization, Inc.

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DATE OF REVIEW: APRIL 24, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of L3-S1 FMNB, Lt sacroiliac joint injection (64622, 64623, 27096)

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Physical medicine and Rehabilitation, and is engaged in the full time practice of 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)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
724.2	64622, 64623, 27096		Prop						Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI-HWCN-Request for an IRO

Respondent records- a total of 246 pages of records received to include but not limited to: claims mgmnt letter, 12.14.05, 4.5.07; letter 2.28.07, 3.12.07; report, Dr. MMI report, 9.14.05, 2.22.06; RME report, 6.14.05, 2.23.06; DDE report, 12.15.05; Medical records from: Dr. 12.5.05-2.24.05; Dr., 12.7.05;, LPC, 3.20.06; Dr. 2.23.07; Dr. 12.18.05; Dr. 12.18.05, Dr. 2.21.05; Dr.

3.1.05; Dr. 3.24.05; Dr. 4.4.05; Dr. 4.19.05; Dr. 4.19.05; Dr. 4.20.05 and Dr. 8.26.05; MRI Lumbar Spine 12.7.05, Request for IRO

Requestor records- a total of 11 pages of records received to include but not limited to: Medical records Dr 2.23.07; lab tests 2.23.07; Lumbar myelogram, 8.26.05; MRI, 12.7.05

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a employee with reported. She has had several years of treatment with MRI findings of the L spine revealing a L-4/5 disc protrusion and facet hypertrophy bilaterally at L-4/5 and L-5/S-1. PE documented reveals complaints of pain with palpation of lower lumbar musculature and diminished ROM with Extension and reported increased pain. Documented patient complaints are stiffness, PVM spasm, bilateral radicular leg pain and weakness in the upper and lower left leg.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

The clinical records provided do not support a medical need for Left FNMB-a diagnostic test for Facet Joint pathology. This is NOT a therapeutic injection; it is purely a diagnostic injection. Further more, the performance of FMNB should not be linked with any other diagnostic or therapeutic injection as it will render interpretation of the causative factors invalid. There is no medical indication for SIJ injection based on medical records provided.

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
- XX 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 (ISIS Spine Treatment Guidelines)