



Specialty Independent Review Organization

## Notice of Independent Review Decision

**DATE OF REVIEW:** 4/24/08

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

The services under dispute include a 2 level lumbar facet block.

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

The reviewer is a medical doctor who is board certified in Physical Medicine and Rehabilitation.

**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)

The reviewer disagrees with the previous adverse determination.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties:  
and Dr.

These records consist of the following (duplicate records are only listed from one source): Dr. MDR letter of 3/19/08, 2/11/08 denial letter by Dr. request for reconsideration letter of 2/27/08, 2/28/07 thoracic and lumbar MRI reports, radiology report of 1/29/08, 2/22/08 denial letter by Dr. and 2/19/08 exam notes.

no additional records than those already mentioned.

We did not receive a copy of the ODG Guidelines from Carrier/URA.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient was injured on the job according to the records provided. He sustained a T9 vertebral fracture and a T12 burst fracture which was managed by T12 kypholasty. He has been treated with lumbar ESI's and lumbar surgery. A note from the treating provider indicates that this review was supposed to be for a 2 level and not a 3 level review as was initially performed by the carrier.

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

The reviewer quotes the ODG as his main source for the recommended protocol. They indicate the following:

**Criteria for use of therapeutic intra-articular and medial branch blocks, are as follows:**

1. No more than one therapeutic intra-articular block is recommended.
2. There should be no evidence of radicular pain, spinal stenosis, or previous fusion.
3. If successful (pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive).
4. No more than 2 joint levels may be blocked at any one time.
5. There should be evidence of a formal plan of additional evidence-based activity and exercise in addition to facet joint injection therapy.

Based upon the above-quoted information, the request for a two level lumbar facet block is approved. The patient does meet the above mentioned criteria.

**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)**