

SENT VIA EMAIL OR FAX ON  
Apr/14/2009

## True Decisions Inc.

An Independent Review Organization  
835 E. Lamar Blvd. #394  
Arlington, TX 76011  
Phone: (214) 717-4260  
Fax: (214) 594-8608  
Email: rm@truedecisions.com

### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Apr/09/2009

**IRO CASE #:**

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

Bilateral lumbar facet injection L3-S1

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

Board Certified in Physical Medicine and Rehabilitation  
Subspecialty Board Certified in Pain Management  
Subspecialty Board Certified in Electrodiagnostic Medicine  
Residency Training PMR and ORTHOPAEDIC SURGERY

**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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

OD Guidelines

Denial Letters 2/11/09, 3/3/09, 3/9/09

Dr. 2/5/09 thru 3/5/09

MRI 1/15/09

CT Lumbar Spine No Date

Ortho & Spine Associates 1/23/09 and 12/4/08

**PATIENT CLINICAL HISTORY SUMMARY**

This is a man injured in xx/xxxx. He subsequently underwent an anterior spinal fusion from L3 to S1. He has ongoing chronic low back pain going to the buttocks and chronic lower extremity pain. An MRI done in 2008 or 2009 (date not clear on the report) that showed the prior surgery and "mild facet arthrosis" at L1/2. The original request for authorization for a lower lumbar facet injection was changed for one for L1/2. Dr. wants to perform this twice prior to a rhizotomy for pain control. The examination shows generalized lumbar tenderness and restricted motion of the lumbar spine.

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

The value of facet injections is questioned in the ODG. First, the ODG recognizes the need for diagnostic blocks. It also recognizes the problems in establishing a clinical diagnosis. Dr. is looking at a diagnostic rather than a therapeutic block. The ODG does not find support for therapeutic blocks, but its indications are largely for the single block followed, if appropriate, by a medial branch rhizotomy. This appears to be Dr. plan. Therefore a single bilateral injection may be reasonably approved.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION**

ACOEM-AMERICA 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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)