

# I-Decisions Inc.

An Independent Review Organization  
71 Court Street  
Belfast, ME 04915  
Phone: (207) 338-1141  
Fax: (207) 470-1032  
Email: manager@i-decisions.com

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** December 1, 2009

**IRO CASE #:**

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

Right T11/T12 L1 Facet Nerve Block with Total IV Anesthesia 64470, 64472, 77003, 01992

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

MD, Board Certified in Physical Medicine and Rehabilitation  
Board Certified in Pain 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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

ODG Guidelines and Treatment Guidelines  
Adverse Determination Letters, 10/16/09, 10/28/09  
Initial History and Physical, MD, 10/2/09  
Lumbar MRI w/3D, MD, 3/11/09  
Preauthorization Request, Pain Consultants, Dr.10/13/09

**PATIENT CLINICAL HISTORY SUMMARY**

This is a man who injured his back on xx/xx/xx while lifting lumber. His MRI showed a right central disc herniation at L4/5 without nerve root compression. The thoracolumbar region was not described. He had an MRI showing compression of his right L5 root. Another note described a prior ESI for the lumbar disc herniation. The examination provided described a positive right SLR at 90 degrees, symmetrically reduced knee and ankle jerks, no motor loss, but reduced right L5 sensation. He had local tenderness at the T11/T12 and T12/L1 region.

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

The ODG does not recommend thoracic facet joint injections as there is limited research and their value has not been proven. In addition, the injections would require evidence of failure of prior treatments, and none were provided. Further treatment options including possible neurectomy or therapeutic exercise were not mentioned in the records provided for this independent review. Without these criteria being addressed, the reviewer is unable to recommend as medically necessary this procedure. The reviewer finds that medical

necessity does not exist for Right T11/T12 L1 Facet Nerve Block with Total IV Anesthesia 64470, 64472, 77003, 01992.

Facet joint injections, thoracic

Not recommended. There is limited research on therapeutic blocks or neurotomies in this region, and the latter procedure (neurotomies) are not recommended. Recent publications on the topic of therapeutic facet injections have not addressed the use of this modality for the thoracic region. (Boswell, 2005) (Boswell2, 2005) Pain due to facet joint arthrosis is less common in the thoracic area as there is overall less movement due to the attachment to the rib cage. Injection of the joints in this region also presents technical challenge. A current non-randomized study reports a prevalence of facet joint pain of 42% in patients with chronic thoracic spine pain. This value must be put into perspective with the overall frequency of chronic pain in the cervical, thoracic and lumbar region. In this non-randomized study, 500 patients had 724 blocks. Approximately 10% of the blocks were in the thoracic region, with 35.2% in the cervical region and 54.8% in the lumbar. (Manchikanti, 2004)

**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 REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**

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