ZRC MEDICAL RESOLUTIONS INC

DATE OF REVIEW: 06/01/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Lumbar facet injections

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:
M.D., Board Certified in Anesthesiology by the American Board of Anesthesiology with Certificate of Added Qualifications in Pain Management, in practice of Pain Management full time since the early 90's

REVIEW OUTCOME:
"Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

__X __Upheld (Agree)

_____Overturned (Disagree)

_____Partially Overturned (Agree in part/Disagree in part)

The medical necessity has not been demonstrated for diagnostic lumbar facet injections. ODG was not found to be helpful in this case and the reviewer utilized more appropriate guidelines, which were within the parameters of this case.

INFORMATION PROVIDED FOR REVIEW:

1. TDI referral
2. URA findings, 4/20 to 4/20/2009
3. MD, office notes, 3/16 to 5/6/2009
4. MD, office notes, 3/9 to 4/4/2009
5. PT notes, 3/9/2009 to 3/16/2009
6. MRI, lumbar study, 3/18/2009
7. Emergency Center, office notes, 3/3/2009

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

181 Ruby Lake Drive
Kyle, TX 78640
512.535.2922 * 512.853.9371 (fax)

This individual was injured on xx/xx/xx and has persistent low back pain after physical therapy and medications. Physical examination is suggestive of facet dysfunction.

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

The National Guideline Clearing House Criteria for performing diagnostic and therapeutic lumbar facet injections stipulates that there should be a failure of six months of noninvasive therapy such as physical therapy, medications, or manual therapy. This criteria has not been met. This individual is three months post injury.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR DECISION:

(Check any of the following that were used in the course of your review.)

_____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 judgment, 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 national accepted medical literature (provide a description).
__X __Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.) National Guideline Clearing House Criteria for Cervical or Lumbar Facet Neurotomy

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