

SENT VIA EMAIL OR FAX ON  
Apr/14/2010

## 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/13/2010

**IRO CASE #:**

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

1 session of outpatient lumbar facet medial branch blocks bilaterally at L4/5; **Physical Therapy 3 X wk X 2 wks for total 6 sessions**

**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 3/15/10 and 3/3/10  
11/4/09 thru 3/16/10  
Dr. 2/3/10  
MRI 11/2/09  
Medical Group 2/3/10  
Dr. 10/29/09 thru 1/27/10  
8/26/09 thru 10/28/09  
11/9/09  
X-Ray 10/29/09

## **PATIENT CLINICAL HISTORY SUMMARY**

This is a man injured on xx/xx/xx lifting an 80-pound pallet. He was diagnosed with a sprain. He remained symptomatic. He was found to have a lot of psychological distress and received counseling for this. The MRI from 11/2/09 showed L5/S1 anterolisthesis without stenosis, facet hypertrophy or foraminal narrowing. There is a disc bulge at L3/4 and broad protrusion at L4/5. None showed any nerve root compression. The examinations showed local tenderness at the L4/5/S1 level over the spinous processes and paraspinal tenderness. Dr. described pain with facet rocking and pain at the facet region.

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

Dr. (3/16/10) stated that the request was for a diagnostic block and not a therapeutic one. The first issue is whether or not there is the possibility of facet pain. The ODG description is vague and as such, this person meets the requirements of local pain and tenderness at the facet region without evidence of a radiculopathy. The ODG accepts the role of facet injections/MBB for diagnostic, and not therapeutic, purposes prior to a neurectomy. Dr. states the intent is a diagnostic block to be followed by therapy. That criterion is not covered in the ODG. Dr. stated this man met all 11 criteria for the MBB. A criterion 1 is a post injection assessment. Criteria 5,6,and 7 are related to the immediate performance of the block. While the diagnosis of facet generated pain is not clear, that is the role of a MBB. Again, per the ODG, the sole indication for this procedure is a possible neurectomy. Again, that was not posed as a treatment option. Without this, the IRO reviewer's medical assessment is that the procedure is not medically necessary.

***This person already had 6 sessions of PT as noted by the therapist, M Muellner. Dr. Nadeem requested the additional therapies to follow the block. Since the block does not meet the ODG criteria as being medically necessary, then the therapy is also not justified.***

## **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)