

SOUTHWEST MEDICAL EXAMINATION SERVICES, INC.
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Notice of Independent Review Decision

DATE OF REVIEW: July , 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Repeat bilateral thoracic spine facet injections T8, T9 and T10, outpatient.

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

DIPLOMATE, AMERICAN BOARD OF ANESTHESIOLOGY

SUITE 800

DIPLOMATE, AMERICAN ACADEMY OF 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

Medical records from the Carrier include:

- Texas Department of Insurance, 06/18/10
- , 05/10/10, 05/24/10
- , 12/10/09
- Surgery Center, 01/26/10
- Imaging, 03/03/10
- M.D., 03/16/10, 05/03/10, 05/19/10

Medical records from the URA include:

- Official Disability Guidelines, 2008

Medical records from the Provider include:

- M.D., 11/04/09, 11/18/09, 12/02/09, 12/15/09
- , 12/10/09
- M.D., 01/08/10, 02/15/10, 03/16/10, 05/03/10
- Surgery Center, 01/26/10
- Imaging, 03/03/10

PATIENT CLINICAL HISTORY:

The description of services in dispute is for repeat bilateral thoracic spine facet joint injections at T8, T9, and T10.

The review outcome is upheld, previous non-authorization for the requested services.

The Guidelines references used are the Official Disability Guidelines, Treatment Index, under Facet Joint Injections.

The patient is a female who sustained a work-related injury on xx/xx/xx, involving the neck secondary to occurring while riding on a service elevator when the cage closed down on her neck. The patient reported

severe, excruciating and intractable pain in the cervical spine with radiculopathy. The patient was diagnosed as having a cervical disc herniation via clinical and objective findings (i.e. cervical MRI).

The patient underwent a cervical epidural steroid injection that was performed on January 26, 2010. The patient subsequently reported mid back pain, and therefore, a thoracic MRI was performed on March 3, 2010, which was read as normal.

The notes submitted indicate the patient underwent thoracic facet joint injections on April 20, 2010. A followup note on May 3, 2010, indicated the patient's mid back pain had returned.

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

After a review of the information submitted, the previous non-authorization for repeat of thoracic facet joint injections has been upheld. It is not clear to the reviewer why the requesting provider would repeat a procedure which has noted limited efficacy (lasting effect only two weeks with previous injection).

In accordance with the ODG Guidelines, Treatment Index, 8th Edition (Webb), 2010, thoracic facet joint injection is not recommended. There is limited research on therapeutic blocks or neurotomies in this region and the latter procedure (neurotomies) are not recommended. The recent publications on the topic of therapeutic facet injections have not addressed the use of this modality for thoracic pain. Pain due to facet joint arthrosis is less common in the thoracic area, as there is overall less movement due to detachment to the ribcage. An injection of joints in this region also presents a technical challenge. A current, nonrandomized study reported a prevalence of facet joint pain of 42% in patients with chronic thoracic spine pain. This study must be put into perspective with the overall frequency of chronic pain in the cervical, thoracic, and lumbar regions. The current evidence is conflicting as to the performance of this procedure.

At this time, no more than one therapeutic intra-articular block is suggested. If successful (pain relief of at least 50% for duration of at least six weeks), the recommendation is to proceed with medial branch diagnostic block and a subsequent neurotomy.

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 KNOWLEDGBASE
- 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)