SENT VIA EMAIL OR FAX ON
Aug/02/2010

Applied Resolutions LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Jul/30/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Outpatient diagnostic / therapeutic facet joint blocks L2/3 bilaterally, under fluoroscopy

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Board Certified Orthopedic Surgeon

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:
[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
OD Guidelines
Dr. 05/03/10
06/01/10, 06/17/10

PATIENT CLINICAL HISTORY SUMMARY
The claimant is a male injured on xx/xx/xx when he tried to catch a piece of falling plywood and felt low back pain.

A 05/03/10 noted by Dr. included a review of history. The claimant had a 2001 IDET procedure with relief for 1 month. In 2004 he was using a pump for narcotic therapy and had a trial spinal cord stimulator (SCS) without benefit. The claimant attended therapy in 2001 and 2006. On 11/10/05, he had a 360-degree fusion at L3-4 and L4-5. The 06/02/06 films showed a fracture of the transverse process at L5 and pedicle fixation at L4, L5 and S1 bilaterally. The claimant had low back and bilateral leg pain worsening over 6 months, reporting he was less functional. There was numbness and weakness both legs. Medications included hydrocodone, Soma and Tylenol. X-rays with flexion and extension revealed disc reabsorption with endplate sclerosis at L5-S1 and anterior spurring; spondylosis at left L1-2 and L2-3 with retrolisthesis at L2-3. The claimant had limited flexion with pain and lateral bending revealed spasm bilaterally. Extension and rotation was “positive,” with ipsilateral pain, right equal to left. There was tenderness of the paraspinal muscles, right more than left. Reflexes were intact with 5/5 strength and no paresthesia. The impression was an intact fusion, transitional disease at L2-3 and severe spondylosis at L5-S1. L2-3 facet injection was recommended.

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

Review of the records provided supports the claimant is a, status post an L3-4, L4-5 fusion with an intact fusion, transitional disease evidently at 2 3. He reported an injury, xx/xx/xx.

The medical records of Dr. from 05/03/10 noted relief from intradiscal electrothermal therapy (IDET) back in 2001, a spinal cord stimulator trial, therapy, x-rays, MRI. Fusion was solid at L3 4 and L4 5. Recent complaints were low back and bilateral leg pain. He was taking hydrocodone, Soma, and Tylenol. Request is made for facet blocks at L2-3.

Based on review of the records provided, there is no recent active treatment, physical therapy with stretch, strength, range of motion modalities, a home exercise program, stretch, strength, range of motion, cardiovascular fitness, or oral anti-inflammatory medications, or oral steroid preparations. The claimant continues to complain of low back and bilateral leg pain. It is not clear by these records that the claimant does not have radiculopathy. Official Disability Guidelines state that facet injections are not recommended in the presence of radiculopathy. ODG also requires failure of conservative treatment for at least 4-6 weeks before proceeding with facet injections. Therefore, based upon ODG Guidelines the facet injections cannot be recommended as medically indicated or necessary.

Official Disability Guidelines 2010. 15th Edition, Low Back
Criteria for the use of diagnostic blocks for facet "mediated" pain:

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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)