

Wren Systems

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jan/14/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

B/L Facet Injections @ T6, T7 & T8 w/fluoro CPT 64470

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 Electrodiagnostic Medicine
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, 11/18/09, 10/12/09
Xxxxxxx 9/24/09
M.D. 9/3/09, 9/24/09
Clinic 8/19/09
Ambulatory Surgery Center (no date)
Medical Imaging 9/21/09

PATIENT CLINICAL HISTORY SUMMARY

This is a woman who apparently developed mid thoracic pain after a fall on x/xx/xx. Dr. notes facet tenderness at T6/7. The MRI was normal. There are notes of an ache from the mid to low back.

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

The only symptom noted for facet pain is local tenderness without any radicular findings. There is one note addressing the local tenderness. Although the ODG recognizes that facet injections are necessary for the diagnosis and possibly the treatment of facet pain, there was not enough material in the records provided to support the diagnosis. In the absence of documentation of the symptoms, the reviewer cannot recommend the facet injections as medically necessary at this time. In addition, the ODG allows only 2 levels to be injected at a time. The bilateral request adds up to 4 levels at this time. This also would not conform to the

guidelines. The reviewer finds that medical necessity does not exist at this time for B/L Facet Injections @ T6, T7 & T8 w/fluoro CPT 64470.

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)