

I-Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jun/23/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Cervical Facet Injection 64490 64491 64492 with MAC 01992

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 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

Adverse Determination Letters, 6/2/10, 5/24/10
International Inc. 5/10/10, 4/12/10, 3/15/10, 12/17/09
MRI & Diagnostic Center 4/30/10
ODG-TWC

PATIENT CLINICAL HISTORY SUMMARY

This is a woman reportedly injured on xx/xx/xxxx. She had undergone prior IDET for disc pain. She has ongoing low back pain that is not subject to this review. She has cervical pain with local tenderness and limited motion. Her cervical MRI (4/30/10) showed minimal disc protrusions at multiple levels. There was mild left Luschka joint arthrtis at C3/4. There was no comment of any facet deterioration at the planned C3/4 and C4/5 levels. The request was for facet injections at C3/4 and C4/5. The examination showed reduced neck motion and local tenderness along the facet joints.

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

The request was for facet injections at C3/4 and C4/5. The first issue is the presence of facet pain. She meets the ODG criteria for local pain and limited cervical motion. The lack of radiological findings is a concern, but does not exclude the presence of a facet problem. The records did not identify all treatments during the past 10 years, although the patient has had

physical therapy. The patient meets the criteria for the use of diagnostic blocks for facet nerve pain. There is failure of conservative treatment. No more than two levels are being requested. There is no surgical procedure anticipated. Based on the guidelines and the records reviewed, the reviewer finds that medical necessity exists for Cervical Facet Injection 64490 64491 64492 with MAC 01992.

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)