

SENT VIA EMAIL OR FAX ON
Oct/08/2010

Applied Assessments LLC

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Oct/05/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Bil L4/5, L5/S1 facet injection with fluoro & monitored anesthesia

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 8/30/10 and 9/13/10
Consultants 10/13/08 thru 9/7/10
OP Report 12/12/08 and 5/16/08
Center 8/27/09
MRI 9/15/05
Solutions 10/24/04 and 10/12/05

PATIENT CLINICAL HISTORY SUMMARY

This man was injured in xxxx. He has ongoing back pain with radicular symptoms in his lower extremities. He had an MRI in 2005 that showed a Stage I spondyloytic spondylolithesis at L5/S1 with facet changes in the mid to lumbar spine and significant foraminal narrowing at

L4/5. His examination showed reduced sensation bilaterally in the L4/5 region. He has had variable responses to prior therapeutic facet injections with 30-70% relief for several months. Dr. noted that he generally has 6 months of relief.

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

We are discussing a therapeutic facet injection. These have provided some relief for several months and Dr. noted reduced amounts of pain medication used. This man is against RF treatment. The World Institute Pain's evidence based guidelines as published in Pain Practice 10(5) 2010: 459-469 states that facet pain "...diagnosis must be confirmed by a diagnostic block of the suspected painful facet joints. If this treatment produces a pain reduction of at least 50%, moving to a RF treatment seems justified. If RF treatment is contraindicated, a 1-time intrarticular injection with local anesthetic can be considered." This criterion would appear to negate the appropriateness of the repeat injections. This would also appear to be the approach taken by the ODG. The ODG notes that the use of repeated blocks is common but not recommended treatment. The ODG further excludes the therapeutic joint injection in the presence of stenosis and radiculopathy. Both are present in this case. Yet this seems to be an exclusion when a neurotomy is being considered. From these different sources, the role of the therapeutic injection is not considered appropriate. Yet, we have a man with several months of relief after these therapeutic injections over several years. Again, Dr. noted the reduction in the use of pain medication. The ODG does look at this contradiction. It states that "The publications are guidelines, not inflexible prescriptions and they should not be used as sole evidence for an absolute standard of care. Guidelines can assist clinicians in making decisions for specific conditions...but they cannot take into account the uniqueness of each patient's clinical circumstances." It would appear to me that Dr. has described the "uniqueness" of this patient's circumstance to warrant the variance. Therefore, the request is medically necessary at this time.

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)