

SENT VIA EMAIL OR FAX ON
Jan/10/2011

True Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jan/10/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

1 Diagnostic Lumbar Facet Block

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

Medical physician Board-certified in Physical Medicine and Rehabilitation
Medical Director of Rehabilitation Medicine

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 10/29/10 and 11/22/10

Dr. 9/1/10 thru 12/20/10

MRI 9/29/10

Pain Management Center 11/15/10

PT Notes 9/8/10 thru 10/27/10

PATIENT CLINICAL HISTORY SUMMARY

This claimant has a date of birth of xx/xx/xx. On xx/xx/xx she was descending a ladder carrying a box and fell. She landed on her head and left side. She reports loss of consciousness for one minute. A CT of the cervical spine was normal. A head CT was normal. She did have a clavicle fracture. Lumbar MRI shows facet OA and no foraminal stenosis. She has had PT. There is low back pain with radiation to the lower extremities. She uses vicodin and lidoderm patch for the pain.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS

AND CONCLUSIONS USED TO SUPPORT THE DECISION

The ODG guidelines state that facet injections can be considered in back pain if the back pain is non-radicular. The guidelines indicate that the level and side should be specified. Facet injections should be considered only if neurotomy is being contemplated. The 11/15/2010 notes indicates that the facet injection is being considered to increase function and for improvement with therapy/exercise.

The request is not consistent with the guidelines as the patient exhibits radicular pain and because neurotomy is not being considered and because the level and side for facet joint injection was not specified.

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)