SENT VIA EMAIL OR FAX ON
Dec/27/2010

Pure Resolutions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Dec/27/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Outpatient bilateral T8/T9 and T9/T10 costo-vertebral injections and two (2) sessions post injection therapy consisting of therapeutic exercises for no more than 4 units per session as related to the thoracic spine

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:

[ ] Upheld (Agree)

[X] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
OD Guidelines; X-ray left shoulder 11/19/07; X-ray lumbar spine 1/19/07; Clinic office notes 12/20/07, 01/04/08, 01/14/08, 01/24/08, 08/03/10, 10/04/10, 11/19/10; X-ray lumbar spine 12/20/07; X-ray dorsal spine 12/20/07; MRI thoracic spine 01/07/08,
MRI lumbar spine 01/07/08; Dr. office notes 01/30/08, 02/05/08, 02/27/08, 03/17/08, 05/12/08; Peer review 11/11/08; Chest x-ray report 06/02/10; Dr. office notes 10/21/10, 11/04/10, 12/03/10; Utilization reviews 11/11/10, 11/23/10

PATIENT CLINICAL HISTORY SUMMARY
This is a male with a date of injury of xx/xx/xx. The claimant was in a motor vehicle accident. The MRI of the thoracic spine from 01/07/08 showed diffuse and wide based disc protrusion at L4-5 causing bilateral foraminal stenosis. Centrally protruded disc measured approximately 3.3 centimeters. Mild to moderate spinal stenosis was reported. Spinal canal measured approximately 6.6 millimeters. There was ligamental thickening and hypertrophic changes seen at the facet joint. There was desiccated disc at L3-4 with narrowing of the neural foraminal bilaterally, more on the right side. Flattening of the thecal sac and no abnormal mass lesions were seen in the thecal sac. On 02/27/08, the claimant underwent a lumbar

epidural steroid injection without any benefit. On 05/12/08 Dr. recommended chiropractic treatment.

On 11/14/10, Dr. evaluated the claimant. The claimant had not been seen for two years. The claimant noted thoracic spine pain. A slightly positive sitting root test was noted. Reflexes were intact. Strength was decreased to the right extensor hallucis longus. Rotation of the thoracic spine increased the pain. Lhermitte maneuver and Spurling maneuver on the neck made it worse. Diagnosis was thoracic spine pain due to costovertebral or facet dysfunction. Dr. has recommended diagnostic or therapeutic corticosteroid injection to the T9 level. Dr. clarified in his 12/03/10 note that the request was for thoracic facet injections at T9.

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

The evidence based ODG literature suggest that facet mediated pain can be identified in individuals who have tenderness in the paravertebral area, normal sensory examination, absence of radicular findings. The indications for facet blocks should include consistent clinical presentation, be limited to the claimants with back pain of a non radicular nature, failed conservative treatment and no more than two levels should be recommended.

Based on the records provided, it appears as though there was some confusion as to the types of blocks that were recommended. Apparently it was suggest that there was some type of sclerosing agent to be recommended and/or ligaments were to be injected as opposed to the facet joints. In Dr. correspondence of 12/03/10 he specifically states facet injections were indicated for diagnostic purposes. He has recommended two levels with a short course of physical therapy thereafter. He has not recommended any sclerosing agents.

The request would appear to meet the evidence based criteria. It appears as though the request is for diagnostic/therapeutic purposes and thus should be considered reasonable and medically necessary. The records have documented a long history of pain complaints and the failure of conservative care including chiropractic on occasions.

The request for post injection therapy 1-2 sessions would also appear also to be consistent with the evidence based literature.

Based on the information provided it appears that the claimant would meet the reasonable evidenced based criteria for the proposed injections and post injection therapy as outlined.

Official Disability Guidelines Treatment in Workers' Comp 2010 updates, chapter low back and thoracic, diagnostic facet injections, facet signs and symptoms

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)