



Southwestern Forensic
Associates, Inc.

REVIEWER'S REPORT

DATE OF REVIEW: 03/28/12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Cisternal or lateral cervical (C1-C2) puncture; with injection of medication or other substance for diagnosis or treatment (E.G., C1-C2)

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., Board Certified in Anesthesiology by the American Board of Anesthesiology with Certificate of Added Qualifications in Pain Management, in practice of Pain Management full time since 1993

REVIEW OUTCOME:

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

Medical necessity has not been demonstrated for the requested procedure per ODG.

INFORMATION PROVIDED FOR REVIEW:

1. URA findings, 2/22/12 and 3/1/12
2. MD, office notes, 11/10/18 to 1/17/11
3. MD, office notes, 10/8/08
4. Imaging, MRI, 10/8/08
5. Ph.D., office notes, 12/18/08
6. Ph. D., office notes, 2/25/09 to 11/30/09
7. MD, office notes, 4/9/08
8. MD, RME, 10/5/10

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

This individual sustained an assault on xx/xx/xx and developed multiple injuries. Headaches persist. Bilateral C2/C3 radiofrequency ablation was performed on 12/38/12, which provided temporary relief. Other diagnoses include traumatic brain injury, PTSD, and diabetes. On 03/17/09 a C1/C2 bilateral intraarticular facet injection was performed, which provided 80% pain relief on follow-up on 04/01/09. A note on 06/10/09 revealed significant headaches. A second procedure was done on 09/03/09 and again on 02/23/10. There is documentation that immediate relief occurred, but the duration is not specified. On 05/18/11 intraarticular C1/C2 injections were requested and denied. The last office visit was 02/17/12.

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

ODG do not endorse therapeutic facet injections. There is lack of literature supporting this procedure. The record does not stipulate the duration of relief from each injection. ODG are not met for the requested procedure.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR DECISION:

(Check any of the following that were used in the course of your review.)

- ACOEM-American 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 judgment, 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)