

SENT VIA EMAIL OR FAX ON
Jun/25/2012

P-IRO Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Jun/25/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

T6-8 facet point injections

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

Anesthesiology/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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

01/24/11 – CLINICAL NOTE –MD

02/02/11 – CLINICAL NOTE –MD

02/09/11 – OPERATIVE REPORT

03/02/11 – CLINICAL NOTE –MD

03/30/11 – CLINICAL NOTE –MD

04/27/11 – CLINICAL NOTE –MD

05/25/11 – CLINICAL NOTE –MD

06/20/11 – CLINICAL NOTE –MD

07/20/11 – CLINICAL NOTE –MD

08/17/11 – CLINICAL NOTE –MD

09/14/11 – REQUIRED MEDICAL EXAMINATION –MD

09/14/11 – CLINICAL NOTE –MD

09/27/11 – CLINICAL NOTE –DC
10/12/11 – CLINICAL NOTE –MD
10/15/11 – MRI CERVICAL SPINE
10/19/11 – DESIGNATED DOCTOR EVALUATION –MD
10/19/11 – REPORT OF MEDICAL EVALUATION
10/20/11 – CLINICAL NOTE –DC
11/09/11 – CLINICAL NOTE –MD
01/03/12 – CLINICAL NOTE –MD
01/31/12 – CLINICAL NOTE –MD
02/27/12 – CLINICAL NOTE –MD
02/28/12 – CLINICAL NOTE –MD
03/27/12 – CLINICAL NOTE –MD
04/16/12 – UTILIZATION REVIEW DETERMINATION
04/16/12 – PRIOR REVIEW –DO
05/03/12 – CLINICAL NOTE –MD
05/11/12 – PRIOR REVIEW –DO
05/11/12 – UTILIZATION REVIEW DETERMINATION
05/25/12 – REQUEST FOR REVIEW BY INDEPENDENT REVIEW ORGANIZATION
06/01/12 – PRIOR REVIEW –MD
06/01/12 – UTILIZATION REVIEW DETERMINATION
06/04/12 – NOTICE TO INC OF CASE ASSIGNMENT

PATIENT CLINICAL HISTORY [SUMMARY]

The claimant is a female who sustained an injury on xx/xx/xx when she slipped and fell on a construction site. The claimant underwent right T6-7 myofascial trigger point injections on 02/09/11. The claimant reported no relief from the injections. MRI of the cervical spine performed 10/15/11 revealed borderline to mild spinal canal stenosis at C4-5, C5-6, and C6-7. The neural foramina were compromised. There was straightening of the cervical spine. There was disc desiccation and bony hypertrophic change at C2-3 and C3-4. The claimant saw Dr. on 01/31/12 with complaints of non-radiating upper back pain rating 8 out of 10. Physical exam revealed decreased range of motion of the neck and low back with paravertebral muscle tenderness. Muscle spasms were palpated at T6-7 and T7-8. There were no sensory or motor deficits. There was no evidence of muscle wasting. The bilateral deep tendon reflexes were equal. The claimant was recommended for facet injections. The claimant saw Dr. on 02/28/12. The claimant's medications included Amrix, Lidoderm patches, Cymbalta, and Norco. Physical exam revealed decreased range of motion of the neck and low back with paravertebral muscle tenderness. Spasms were noted bilaterally in the thoracic region. There were no motor or sensory deficits noted. There was no evidence of muscle wasting. The bilateral deep tendon reflexes were equal. The claimant was recommended for facet injections.

The claimant saw Dr. on 05/03/12 with complaints of severe pain in the thoracic region. The claimant reported minimal relief from myofascial trigger point injections. The claimant rated her pain at 3 out of 10, but stated it increased to 8 out of 10 with any activity. The claimant described pain as intermittent sharp, stabbing pain, greater on the right side of her thoracic area. The claimant also reported numbness along the right thoracic region that was radiating in nature. The claimant's medications included Flexeril, Lidoderm patches, and Norco. Physical exam revealed markedly decreased truncal range of motion with increased pain. There was exquisite tenderness to palpation over T7 through T10, more so in the right paravertebral region with palpation of the thoracic facets. Sensation was intact. The claimant was recommended for diagnostic facet injections to the right T6-7, T7-8, and T8-9 facet joints. The request for T6-8 facet point injections was denied by utilization review on 05/11/12 due to a lack of efficacy documented in the literature and a lack of well-done medical research published on this type of injection. The request for T6-8 facet point injections was denied by utilization review on 06/01/12 due to no diagnostic imaging studies indicating facet pathology. The claimant reported radicular pain, and guidelines recommend the use of facet joint injections in patients with no evidence of radicular pain. Additionally, this intervention was not recommended for the thoracic spine.

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

Based on the clinical documentation provided for review and current evidence based guideline recommendations regarding facet injections, medical necessity is not established for the request. The claimant reported upper back pain that did not respond to trigger point injections or medications. The claimant's physical exam revealed loss of range of motion in the thoracic spine as well as tenderness to palpation over the T6-8 facet joints. The clinical documentation provided for review did not indicate whether the requested facet joint injections were diagnostic or therapeutic in nature. Additionally there was no discussion regarding a continuation of evidence based conservative treatment that would be used as an adjunct to the requested injections. As the medical need for the requested service is not established per guideline recommendations, the prior denials are upheld.

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 KNOWLEDGBASE
- 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)