

# I-Decisions Inc.

An Independent Review Organization  
5501 A Balcones Drive #264  
Austin, TX 78731  
Phone: (512) 394-8504  
Fax: (207) 470-1032  
Email: manager@i-decisions.com

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Mar/05/2012

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**  
Cervical Facet Injection under Fluoroscopy and IV Sedation

**DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**  
M.D., Board Certified Anesthesiology

**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**

Official Disability Guidelines  
Utilization review determination dated 02/03/12, 01/11/12  
Follow up note dated 01/18/12, 12/05/11, 11/07/11  
CT cervical, lumbar and thoracic spine dated 01/28/11

**PATIENT CLINICAL HISTORY SUMMARY**

The patient is a male whose date of injury is xx/xx/xx. On the date of injury the patient was involved in a motor vehicle accident when another car pulled out right in front of him causing him to strike a pole head on at 45 mph. The airbags did not deploy. Treatment to date is noted to include physical therapy and medication management. The patient complains of headache, neck and upper back pain as well as low lumbar pain. Medications include Protonix and Motrin. Note dated 12/05/11 indicates that the patient is currently working. The patient has decreased neck range of motion. He has exquisite tenderness over the facet regions from C2-3 through C5-6.

Initial request for cervical facet injection was non-certified on 01/11/12 noting that the request is not specified to the number of cervical facet injections and there is no documentation of exhaustion of lower levels of care. The patient was previously rejected for the same reasons in November 2011, and no additional documentation is provided to support additional failed lower levels of care. Follow up note dated 01/18/12 indicates that the patient's pain is aggravated with side bending and extension and radiates to the shoulder. CT of the cervical spine dated 01/28/11 revealed normal appearance at C2-3. At C3-4 there are no significant facet degenerative changes. At C4-5 there are no significant facet degenerative changes. At C5-6 there is some facet hypertrophy. At C6-7 there is facet hypertrophy. The denial was upheld on appeal dated 02/03/12 noting that there is no documentation of home exercise program prior to this procedure for the last 4-6 weeks. The treating provider has not documented how many joint levels for the cervical facet injections.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS**

**AND CONCLUSIONS USED TO SUPPORT THE DECISION**

There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. The patient's compliance with an independent, self-directed home exercise program is not documented. The request is nonspecific and does not indicate which level/s is/are to be injected. Given the current clinical data, it is the opinion of the reviewer that the requested Cervical Facet Injection under Fluoroscopy and IV Sedation is not 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)