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DATE OF REVIEW: 11-19-07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Bilateral L4-L5 facet injections

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

Certified by The American Board of Physical Medicine & Rehabilitation

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)

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS, CPT, NDC Codes	Service Units	Upheld/Overturn
xx/xx/xx	xxxxxxxx	Prospective	721.3	64475	1	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Notice of Decision Determinations dated 10-23-07 & 10-25-07
Case Reports dated 10-23-07 & 10-25-07

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Pre-authorization Request dated 10-09-07
Progress note dated 09-19-07
MRI report dated 10-05-07
Criteria/Guidelines Utilized: ODG (noted but not provided)

PATIENT CLINICAL HISTORY:

This is a gentleman who was injured on xx/xx/xx. The claimant complained of low back pain and lower extremity “tingling”. The progress note dated 09-19-2007 noted that the claimant had a disc replacement in 08-2006 and left lower extremity “does have quite significant paresthesias”. The physical examination noted left lower extremity “subtle left dorsiflexion weakness”. There was no sensory loss and 2+ reflexes. A repeat MRI was to be obtained.

The repeat MRI noted the implant and moderately severe facet arthrosis at L3-4, L4-5 and L5-S1.

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

In the opinion of the physician Reviewer, the requested procedure is not medically necessary for this claimant. The Reviewer noted that the presenting complaints were back and leg pain. These injections are not addressing the complaints presented; this procedure is only addressing the ordinary disease of life degenerative pathology noted on MRI. The Reviewer also commented that the physical examination offered by the requesting provider did not objectify any facet joint issues or presentations. In addition, review of the literature clearly does not support this approach. As noted in the ODG, “this type of procedure is not currently recommended as a treatment modality in most evidence-based reviews as their benefit remains controversial. The therapeutic facet joint injections described here are injections of a steroid (combined with an anesthetic agent) into the facet joint under fluoroscopic guidance to provide temporary pain relief. (Dreyfuss, 2003) (Nelemans-Cochrane, 2000) (Carette, 1991) (Nelemans, 2001) (Slipman, 2003) (vanTulder, 2006) (Colorado, 2001) (ICSI, 2004) (Bofduk, 2005) (Resnick, 2005)”. According to the Reviewer, given the surgery completed, this would not be appropriate.

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A Description and the Source of the Screening Criteria or Other Clinical Basis Used to Make the Decision:

- 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 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)**