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Revised Report

Corrected Right to Appeal (see page 3)

DATE OF REVIEW: 10-08-07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Bi-lateral lumbar facet u/fluoroscopy

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

Certified by The American Board of Orthopedic Surgery

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
		Prospective	721.0	64475, 64476, 77003	1	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Utilization Review Decision dated 06-29-07 & 08-14-07
 Workman's Compensation – Follow-up dated 02-01-07, 03-15-07, & 06-28-07
 Progress Note dated 05-11-07
 Designated Physician Examination dated 03-26-07

ODG Guidelines (2007 5th Edition). Treatment in workman's compensation.
Chapter: Low back. Facet joint diagnostic blocks (injections)

PATIENT CLINICAL HISTORY:

The medical records presented for review indicate that on the date of injury the claimant was lifting a child who was thrashing and the claimant reportedly sustained a low back injury. The past medical history is significant for a prior injury to the lumbar spine.

The February 1, 2007 progress note indicates that the claimant is feeling much better. The assessment relates to a myofascial low back strain. Imaging studies noted disk degeneration with a small herniation. Epidural steroid injections (ESI) were suggested and the injections were completed with excellent results.

A Designated Doctor examination noted that maximum medical improvement had been reached. The narrative report indicates that the lumbar spine injury was a disk lesion with radiculopathy.

The next progress note from the treating physician noted a stable spine with ongoing complaints of pain. A request was made for facet injection. This request was not certified. An appeal was noted and also not certified.

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

As noted by the medical records of the requesting provider, and as noted by the Designated Doctor the lumbar spine injury resulted in a disk lesion with herniation and radiculopathy. These sequale will not be addressed with a multiple level facet injection. Therefore, this would not be reasonably required to address the compensable injury. Furthermore, there is no clinical data presented to indicate that these injections are warranted. Lastly, as noted in the Official Disability Guidelines there is an indication for this type of procedure; however only under specific criteria. These criteria have not been met or presented by the requesting provider. A careful review of the documentation noted indicates no more than two levels that a diagnostic block be performed and there be a significant pathology identified. Therefore there is no medical necessity for the requested procedure.

Lumetra's Physician Reviewer has no known conflicts of interest in this case, pursuant to the Insurance Code Article 21.58A (Chapter 4201 effective April 1, 2007), Labor Code § 413.032, and § 12.203 of this title.

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)