

Clear Resolutions Inc.

An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: AUGUST 3, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Bilateral L4/L5, L5-S1 facet medial nerve block

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

M.D., Board Certified in pain management and anesthesiology under the American Board of Anesthesiologists.

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 or not medical necessity exists for each of the health care services in dispute.

The reviewer finds that medical necessity does not exist for bilateral L4/L5, L5-S1 facet medial nerve block.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 6/30/08, 7/14/08
ODG Guidelines and Treatment Guidelines
Operative Report, 8/29/07
Dr. 10/29/07, 12/5/07, 7/14/08, 4/21/08, 4/7/08, 2/25/08, 1/14/08, 10/9/07, 10/8/07, 6/25/07,
9/10/07, 9/1/07, 8/6/07, 1/30/04, 8/29/07
Dr. 5/20/08, 7/3/08, 7/17/08, 7/30/07, 7/17/08
Dr. 7/30/07, 5/14/08

MRI of Lumbar Spine, 10/29/07
Radiology Reports, 12/5/07
Health Records, 12/5/07-12/8/07
Lumbar Spine, 2-3 Views, 4/7/08
Chest 2 Views, 12/3/07
Single View Chest, 12/5/07

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient was injured on the job on xx/xx/xx. When being evaluated on 07/17/08, the patient complained of pain in bilateral lumbar spine that radiated into the bilateral buttocks, left hip, bilateral posterior thighs, left anterior thigh and left lateral thigh. At this same office visit dated 07/17/08, there is no mention of tenderness to palpation over the facet joint region. The patient also has a history of an L3-L5 redo laminectomy and fusion with pedicle screws. The request is for a bilateral L4-5 and L5-S1 intraarticular facet joint injection.

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

Per the *Official Disability Guidelines*, a patient is considered to have possible facet joint mediated pain if they have tenderness to palpation over the lumbar facet joints. There is no mention of this in the office visit note dated 07/17/08. On the office visit note dated 05/20/08, with palpation of the back there is again “no pain elicited.” The patient is also noted to have “full active range of motion with extension, flexion, left lateral bending, right lateral bending, left rotation and right rotation.” The *Official Disability Guidelines* state that diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level.” This patient has received a fusion from L3-L5 on 04/05/07. Therefore, the request for the L4-5 intraarticular facet joint injection is not consistent with the *Official Disability Guidelines*’ recommendations. The *Official Disability Guidelines* also state that if you are considering intraarticular facet joint injections “there should be no evidence of radicular pain, spinal stenosis or previous fusions” specifically at the levels requested. This patient’s pain is somewhat radicular in nature, but the reviewer would not consider it to be completely radicular in that pain does not travel below the knees. In summary, the main issue the reviewer has with the request is the fact that the patient had a previous fusion at L4-5. In addition, the L5-S1 request does not meet the guidelines in that the patient does not appear to have any facet-related pain. The reviewer finds that medical necessity does not exist for bilateral L4/L5, L5-S1 facet medial nerve block.

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 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)