

True Decisions Inc.

An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: February 25, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient facet block bilateral with fluoro guide L3/4 and L4/5

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

Board Certified Orthopedic Surgeon

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

OD Guidelines
MRI lumbar spine, 05/25/04, 07/23/07
Myelogram, 09/13/04
OR note, 12/11/06
Office notes, Dr. 01/17/07, 02/22/07, 03/29/07, 04/26/07, 05/24/07
X-ray with flexion/extension, 01/22/07
Office notes, Dr. 07/10/07, 08/23/07, 10/30/07
EMG/NCV, 07/23/07
MRI, 09/24/07
CT, 09/24/07
Denials, 01/10/08, 01/16/08
Letter, Mr for Dr., 01/15/08
Letters, 07/31/07, 01/11/08

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a xx year old male injured on xx/xx/xx. He had a subsequent L2-3, 3-4 and L4-5 decompression and discectomy on 12/11/06. Since the surgery the claimant had had back and bilateral lower extremity symptoms more right than left. The 01/22/07 x-rays with flexion/extension showed narrowed disc spaces at L1-2, 2-3, 3-4 and 4-5. There was eburrination and sclerosis with anterior spurring at L1-2, limited flexion and extension and no spondylosis or spondylolisthesis. He was treated by Dr. with medications.

On 07/10/07 Dr. evaluated the claimant for low back and bilateral leg pain, right more than left. On examination there was spasm noted and pain to palpation of the buttocks, right thigh and hips. He had a decreased right patellar reflex and decreased sensation to portions of the right lower extremity. Straight leg raise was positive on right. Heel and toe walking was difficult to assess due to weakness of the right leg and there was some right thigh atrophy. Right lower extremity weakness was noted. X-rays showed narrowing of the L2-3, 3-4 and 4-5 disc spaces. There was a vacuum gas pattern at L1-2 and traction spurs. The 07/23/07 EMG/NCV showed active bilateral L3 to S1 radiculopathy in the motor roots and active denervation in right L3 and left L5. There was reported striking involvement of S2-4 motor roots consistent with bowel and bladder dysfunction. The 07/23/07 MRI of the lumbar spine showed an L1-2 spondylitic disc bulges extending laterally with bilateral facet hypertrophy. There was an L2-3 protrusion, right lateral bulge and right neural canal narrowing and bilateral facet hypertrophy. A right posterolateral disc protrusion was seen at L3-4 with right neural narrowing and thecal sac impingement. There was an L4-5 right disc bulge with right neural canal narrowing.

Dr. noted a progression of pain and symptoms. Left leg strength was 2/5 and there was decreased sensation in the left lower extremity on 08/23/07. Reflexes were bilaterally decreased. The 09/24/07 MRI of the lumbar spine with and without contrast showed an "S" shaped scoliosis centered at L2-3 right and left at L4. L1-2 disc bulge with moderate canal stenosis and moderate left foraminal stenosis. There was an L2-3 and 3-4 bulging annulus causing mild central and bilateral foraminal stenosis. At L4-5 there was a disc bulge causing moderate right and mild left foraminal narrowing. The 09/24/07 CT also showed an S shaped scoliosis to the right at L2-3 and to the left at L4 measuring 12 degrees at both levels. There was a disc bulge and osteophyte to the left at L1-2 leading to moderate canal and left foraminal stenosis. A right laminotomy was seen at L2-3 and 3-4 with disc bulges and mild stenosis of the canal and bilateral foramina. There was a disc bulge at L4-5 with moderate canal and severe right and mild left neural foraminal narrowing.

On 10/30/07 Dr. recommended a decompression and stabilization L3-4 and 4-5 and in the meantime facet injections for L3-4 and 4-5. The request was denied on peer review. In a letter dated 01/15/08 a letter from Mr. for Dr. noted a peer to peer with Dr. The letter noted Dr. felt that claimant had radiculopathy from facet hypertrophy and pain on exam and that he would benefit from injection and also felt epidural steroid injections were not needed based on the facet hypertrophy.

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

The requested facet blocks do not appear indicated based on the information reviewed.

The claimant had previous electrodiagnostic studies that demonstrated radiculopathy. ODG guidelines specifically state that facet injections are contraindicated in the presence of radicular pain. This claimant has radicular pain to the point that he has been considered a candidate for a decompression from L3 through L5. For these reasons, the requested facet injections cannot be judged medically necessary.

Official Disability Guidelines Treatment in Worker's Comp 2008, Low Back
Not recommended except as a diagnostic tool. Minimal evidence for treatment injections); & [Segmental rigidity](#) (diagnosis). Also see [Neck Chapter](#) and [Pain Chapter](#).
Criteria for use of therapeutic intra-articular and medial branch blocks, are as follows:

1. No more than one therapeutic intra-articular block is recommended.
2. There should be no evidence of radicular pain, spinal stenosis, or previous fusion.
3. If successful (pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive).
4. No more than 2 joint levels may be blocked at any one time.
5. There should be evidence of a formal plan of additional evidence-based activity and exercise

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)**