

# Clear Resolutions Inc.

An Independent Review Organization

7301 Ranch Rd 620 N, Suite 155-199

Austin, TX 78726

Fax: 512-519-7316

Notice of Independent Review Decision

**DATE OF REVIEW:** JANUARY 28, 2008

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Lumbar facet block injection

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

M.D., board certified Orthopedic Surgeon, board certified Spine Surgeon, board certified in Invasive Pain Management

**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)

The reviewer finds that the request for a lumbar facet block injection meets neither clinical nor ODG Guidelines criteria and is not medically necessary.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Adverse Determination Letters, 11/30/07, 12/13/07

ODG Guidelines

MD, 11/28/07, 11/2/07, 7/30/07, 4/30/07, 1/22/07, 11/21/06, 7/14/06, 6/13/06, 5/10/06, 4/7/06, 3/24/06, 3/11/06, 2/20/06, 1/23/06, 12/12/05, 12/21/05, 11/30/05, 11/16/05, 10/28/05, 10/21/05, 9/12/05, 8/15/05, 4/1/05, 2/28/05, 2/21/05, /8/05, 10/30/06

Hospital, History & Physical, undated

MRI Lumbar Spine, 2/11/05

CT Lumbar Spine w/Contrast, 1/11/06

Lumbar Diskography, 1/11/06

MRI Cervical Spine, 2/11/05

CT Lumbar Spine, 10/25/05  
CT Myelogram of Lumbar Spine, 10/25/05  
Bilateral L4-5 facet injection and bilateral L5-S1 facet injection, 10/30/06, 10/6/05,  
6/23/05  
L3-4, L4-5, L5-S1 Lumbar Discogram, 1/11/06  
L4-5 Epidural injection with epidurogram, 8/4/05  
Right L4-5 transforaminal epidural injection with epidurogram, 6/23/06  
Letter to IRO, 1/24/08

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This injured employee suffered a work-related injury and has undergone numerous and varied treatment options including epidural steroid injections, a series of facet blocks, discogram. The patient is being offered an endoscopic discectomy, and the pain is apparently said to be radicular in the medical records but is not borne out by the imaging studies. There is no basis to have this reviewer believe, based upon the negative results of previous facet blocks and the medical records, which discuss the ideal treatment options as being endoscopic discectomy, that there was facet-mediated pain.

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

The medical necessity for a lumbar facet block injection is not established in the medical record. The patient has a clear-cut diagnosis of radiculopathy and has had previous blocks, which did not relieve the back pain, although curiously, the physician who performed the facet blocks performed them at L4/L5 and L5/S1 when the abnormalities were at L3/L4 and L4/L5. The radiculopathy was documented as being an S1 radiculopathy by history, yet the MRI scan is, in fact, negative as far as nerve root compression.

Based on the fact that this patient has had previous blocks that have not really relieved the low back pain, the diagnosis, that the medical records are replete with lumbar radiculopathy and endoscopic discectomy, and the fact that this patient's pain complaints do not conform to that expected with facet arthropathy, this request meets neither clinical nor ODG Guidelines criteria and is not medically necessary.

**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)**