

US Decisions, Inc.

An Independent Review Organization

71 Court Street

(512) 782-4560 (phone)

(207) 470-1085 (fax)

Notice of Independent Review Decision

DATE OF REVIEW: 07/14/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Bilateral facet injection at L4-5, L5-S1 with fluoroscopic guidance, epidurogram, and general anesthesia

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)

Upon independent review the reviewer finds that the requested bilateral facet injection at L4-5, L5-S1 with fluoroscopic guidance, epidurogram, and general anesthesia is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 6/17/08, 6/24/08

ODG Guidelines and Treatment Guidelines

, MD, 6/12/08, 6/4/08

MRI of Lumbar Spine, 4/13/06

MRI of Cervical Spine, 4/13/06

Operative Report, 7/5/06

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient has a chief complaint of “lumbar pain with no radiation.” The patient received bilateral L4-L5 facet joint injections in July 2006. These injections were noted to have “helped decrease the pain for 6-8 months.” There is no mention as to what percentage of pain relief the patient actually received or if there was any increase in function. The patient has tried physical therapy and medication management for this pain. Based on the fact that the patient received significant pain relief for 6-8 months, a repeat bilateral L4-5 and L5-S1 has been requested along with general anesthesia and an epidurogram. It is noted on physical exam that there is no mention of tenderness to palpation along the facet joints. The only thing mentioned that is significant regarding the low back pain is a positive straight leg raise on the left.

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

Upon independent review of the provided medical records and ODG Guidelines, this reviewer finds that the requested bilateral facet injection at L4-5, L5-S1 with fluoroscopic guidance, epidurogram, and general anesthesia is not medically necessary. It is noted that the patient has received significant pain relief in the past from facet joint injections although it is not mentioned as to how much pain relief was received or how much function was associated with it. Despite this, the patient’s history as of the office visit note dated 06/04/08 does not sound like facet joint pain. It is noted on physical exam that the patient has a positive straight leg raise on the left and negative on the right. In addition, there is no mention as to any tenderness to palpation over the facet joints. There is also no mention of whether the back pain increases or decreases with lumbar extension or flexion. Therefore, it is difficult to determine exactly where this patient’s pain is originating based on the information provided. Per the *Official Disability Guidelines*, it is suggested that facet joints are the cause of pain if “there is tenderness to palpation in the paravertebral areas over the facet joint regions.” It is also suggested that there be a normal straight leg raise exam which is not the case in this situation. The *Official Disability Guidelines* also go on to state that for the use of therapeutic facet joint blocks “there should be no evidence of radicular pain.” Since this patient has a positive straight leg raise, it appears that this patient has a radicular type of pain. The request for an epidurogram does not make sense because the epidural space is not accessed during a facet joint injection. In addition, this patient does not have a medical history that would require general anesthesia.

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)