

Clear Resolutions Inc.

An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: MAY 25, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar facet injection x1 at L5-S1.

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 there is not medical necessity for lumbar facet injection x 1 at L5-S1.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 3/26/08, 4/25/08
ODG Guidelines and Treatment Guidelines
Care DO, 3/13/08, 3/24/08, 4/7/08, 4/23/08, 5/7/08, 5/13/08
MD, 3/10/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient was injured on the job when he fell off of a trailer that stood about 5 feet tall. Since then, he has complained of low back pain that radiates into the left posterior hip, left posterior thigh, and calf and occasionally into the left foot and even to the sole and heel of the left foot. The most recent note that was dictated by Dr. on 05/07/08 recommends a caudal epidural steroid injection. There is no mention of a facet joint injection. On 04/07/08, there is a request for an L4-5 and L5-S1 facet joint injection. There is no mention of a formal plan of evidence-based activity and exercise to be performed in conjunction with the facet joint injections. In addition, on physical exam there is no mention of tenderness over the L5-S1 facet joints.

There is some tenderness located over the spinous processes at L4 and L5. This was noted on the office note dated 04/23/08. A review of a lumbar spine MRI performed on 04/07/08 states that the patient had a disc bulge at L4-5 and L5-S1. There is no mention of any compression of the spinal cord or any nerve roots. An EMG/NCV performed on 03/10/08 states that there is a suspected left L5 radiculitis. This is not explained by the MRI.

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

Per the *Official Disability Guidelines*, facet joint injections are not indicated if there are radicular findings. It is noted that there can be radicular findings if there is evidence of facet hypertrophy encroaching on the neural foramen. There is no mention of this in any of the notes I have reviewed. In addition, the patient seems to have an abnormal neurological exam. Specifically, Dr. states that the patient has "some weakness particularly in the distal L5 muscles and decreased sensation in the left L5 dermatome." This exam was performed on 03/10/08. Per the *Official Disability Guidelines*, there needs to be a "normal sensory exam" for a facet joint to be considered a possible cause of the patient's pain. Given these issues, the reviewer finds that there is not medical necessity for lumbar facet injection x 1 at L5-S1.

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)