

SENT VIA EMAIL OR FAX ON  
Apr/13/2009

## **P-IRO Inc.**

An Independent Review Organization  
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### **NOTICE OF INDEPENDENT REVIEW DECISION**

**DATE OF REVIEW:**  
Apr/13/2009

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**  
OP L3/4 Bilateral Facet Injection 2nd and 3rd injections

**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  
Dr. Office Records: 12/11/08; 12/30/08; 01/16/09; 02/26/09  
MRI Lumbar Spine: 12/17/08  
Operative Report: 02/20/09

**PATIENT CLINICAL HISTORY SUMMARY**

This male was evaluated on xx/xx/xx by Dr. for a xx month history of lower lumbar pain that radiated into both buttocks and his right anterior thigh which had failed to improve with physical therapy and analgesics. The claimant had a prior history of 2 lumbar fusions approximately xx years ago and currently smokes. Exam findings revealed midline mid and upper lumbar spine tenderness with decreased bilateral patellar and Achilles reflexes. Lumbar x-rays with flexion and extension views revealed interbody fusion with facet screws from L4 to S1 with on motion.

The claimant was diagnosed with degenerative disc disease and prescribed Lortab and a lumbar MRI which was done on 12/17/08 and revealed the prior L4 to S1 fusion as well as L1-2 degenerative disc disease and severe facet arthritis at L3-4. The claimant underwent bilateral L3-4 lumbar facet injections on 02/20/09 with mild improvement. Dr. requested authorization to proceed with the 2nd and 3rd L3-4 facet injections.

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

Request was for the medical necessity of L3-4 bilateral facet injections, second and third.

The claimant underwent previous injections at the above levels 02/20/09 with some short-term improvement. ODG guidelines only recommend one therapeutic intraarticular injection.

It thus does not appear that further injections are indicated at this juncture.

Official Disability Guidelines Treatment in Worker's Comp 2008 Updates: Low Back -- Facet joint intra-articular injections (therapeutic blocks)

ODG guidelines for Facet joint intra-articular injections (therapeutic blocks)

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 (initial pain relief of 70%, plus 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 in addition to facet joint injection therapy

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION**

ACOEM-AMERICA 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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**

**OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**