

Notice of Independent Review Decision

**PEER REVIEWER FINAL REPORT**

**DATE OF REVIEW:** 8/17/2009  
**IRO CASE #:**

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

Lumbar Facet Injection

**QUALIFICATIONS OF THE REVIEWER:**

This reviewer graduated from and completed training in Anesthesiology/Pain Management at. A physicians credentialing verification organization verified the state licenses, board certification and OIG records. This reviewer successfully completed Medical Reviews training by an independent medical review organization. This reviewer has been practicing Anesthesiology since 4/23/1993 and currently resides in .

**REVIEW OUTCOME:**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- |   |                                  |
|---|----------------------------------|
| <input checked="" type="checkbox"/> Upheld    | (Agree)                          |
| <input type="checkbox"/> Overturned           | (Disagree)                       |
| <input type="checkbox"/> Partially Overturned | (Agree in part/Disagree in part) |

Lumbar Facet Injection Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

10780 Santa Monica Blvd #333, Los Angeles CA 90025 , Phone (800) 726-1207 , Fax (800) 726-1207 , [www.admere.com](http://www.admere.com)  
Advanced Medical Reviews, Inc

Name: Patient\_Name

**INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:**

The injured worker is a xxyear old who is diagnosed with foraminal stenosis due to disc protrusion at L3-4, L4-5 and L5-S1. He also complains of lumbar pain on the left side, essentially joint facet pain. He underwent joint facet block at L4-5 and L5-S1 on xx/xx/xx. He was also prescribed Vicodin and Flexeril. He had an EMG/NCV performed on his lower extremities on 6/19/2008.

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

The injured worker is a xx year old who is diagnosed with foraminal stenosis due to disc protrusion at L3-4, L4-5 and L5-S1. He also complains of lumbar pain on the left side, essentially joint facet pain. He was also prescribed Vicodin and Flexeril. There was an MRI that was notable for facet pathology at L34 and L45. The patient had radiculopathy felt to be in the S1 distribution. He had an EMG/NCV performed on his lower extremities on 6/19/2008. There were no abnormal findings noted. It was felt by Dr that the pain was therefore musculoskeletal in origin. He underwent joint facet block at L4-5 and L5-S1 on xx/xx/xx and 11/11/2008. There was indication that the patient had complete relief for 2 months with slow return of the pain. A note dated 5/21/09 indicated the pain had returned. There was a request for a repeat facet injection. This was denied on the basis of both the presence radiculopathy and lack of imaging studies. The ODG guidelines will support facet injections as a diagnostic tool, but do not support repeat therapeutic facet injections. Once the diagnosis has been made there is support for RFTC to provide long term benefit and this procedure can be repeated if there is sustained benefit. Based on the fact that the patient has already had a diagnosis of facet mediated pain (indicated by the patient's response), no further facet blocks are supported by the ODG guidelines. Therefore, the request is not considered medically necessary and the previous denial is upheld.

**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

**X** 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)

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