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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Aug/12/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Bilateral Facet injection @L4-5, L5-S1 (64475) Additional Level (64476) Fluoroscopic Guidance (77003)

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
M.D., Board Certified Orthopedic Surgeon

REVIEW OUTCOME:

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

[X] Upheld (Agree)

[ ] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
ODG Guidelines and Treatment Guidelines
Adverse Determination Letters, 6/24/09, 7/13/09
Employers First Report of Injury, xx/xx/xx
Dr., 10/23/08, 10/23/08, 10/30/08, 11/05/08, 12/04/08, 03/09/09
Dr., DDE, 03/18/09
Dr., 06/12/09
Physical therapy records, 10/28/08 to 11/25/08, 11/04/08
MD Rx, 10/23/08
MRI lumbar spine, 10/29/08
Supplementary report of injury, 10/23/08
Peer Review, 12/15/08
Injection scheduling form, 06/12/09
Pre- authorization request, 06/18/09
Claims correspondence, 12/16/08
Work status, 11/05/08

PATIENT CLINICAL HISTORY SUMMARY
This is a xxx year old female claimant who reportedly was injured on xx/xx/xx when a moving rack fell over and struck her shoulder and caused her body to twist. The claimant was initially

diagnosed with lumbar pain and a left shoulder contusion. A lumbar MRI performed on 10/29/08 showed an annular bulge L4-5 along with mild right and modified left L5- S1 facet arthropathy. Medications, physical therapy and modified duty reportedly provided some relief.

Physician records of 2009 noted the claimant's left shoulder asymptomatic. Examinations revealed extreme point tenderness L5- S1 and low back pain exacerbated with extension. The claimant was diagnosed with a lumbar strain and facet arthropathy L4-5 and L5- S1. Bilateral L4-5 and L5- S1 facet joint injections were recommended.

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

The requested bilateral lumbar facet injections L4-L5 and L5-S1 is not medically necessary based on review of this medical record.

This is a xx-year-old woman who has ongoing back and radicular leg complaints following a xx/xx/xx injury. The records of Dr. 06/12/09 document ongoing back and bilateral leg/foot complaints. He reviewed an MRI 10/29/08 and described lumbar facet arthropathy.

In light of the claimant's ongoing pain and limitations in function, the provider requested lumbar facet blocks. ODG guidelines document the use of lumbar facet blocks in patients who have no evidence of radicular pain, spinal stenosis or previous fusion but do have ongoing back pain and have failed appropriate conservative care.

In light of the fact that this claimant has documented radicular leg complaints which have not been adequately explained, then the requested facet injections are not medically necessary. The reviewer finds that medical necessity does not exist for Bilateral Facet injection @L4-5, L5-S1 (64475) Additional Level (64476) Fluoroscopic Guidance (77003).

Official Disability Guidelines Treatment in Worker's Comp 2009 Updates, Low Back : Facet joint intra-articular injections (therapeutic blocks)

Under study. Current evidence is conflicting as to this procedure and at this time no more than one therapeutic intra-articular block is suggested. If successful (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). If a therapeutic facet joint block is undertaken, it is suggested that it be used in consort with other evidence based conservative care (activity, exercise, etc.) to facilitate functional improvement.

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

[X] 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)