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## Notice of Independent Review Decision

### IRO REVIEWER REPORT – WC (Non-Network)

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**DATE OF REVIEW:** 07/20/09

**IRO CASE #:**

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

Lumbar facet injections at L3-L4 and L4-L5

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR  
OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION**

Board Certified in Orthopedic Surgery

**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.

Lumbar facet injections at L3-L4 and L4-L5 - Upheld

## **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Evaluations with D.O. dated 05/23/06, 04/25/07, 11/15/07, 01/14/09, 01/21/09, 04/29/09, and 06/02/09

Evaluations with P.A.-C. dated 12/18/07, 03/18/08, 06/18/08, 09/18/08, and 05/05/09

An MRI of the lumbar spine interpreted by M.D. dated 01/14/09

A letter of non-certification, according to the Official Disability Guidelines (ODG), from D.O. dated 05/07/09

A letter of non-certification, according to the ODG, from M.D. dated 06/11/09

The ODG Guidelines were provided by the carrier

## **PATIENT CLINICAL HISTORY**

On 05/23/06, Dr. noted the patient was post removal of his hardware and the fusion was solid. On 04/25/07, Dr. recommended a CT scan of the lumbar spine. An MRI of the lumbar spine on 01/14/09 revealed a postsurgical change at L5-S1 with mild degenerative changes of the spine. On 04/29/09, Dr. recommended lumbar facet injections and a caudal epidural steroid injection (ESI). On 05/07/09, Dr. wrote a letter of non-certification for a caudal ESI and lumbar facet injections. On 06/11/09, Dr. wrote a letter of non-certification for the lumbar facet injections.

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

The ODG criteria for use of therapeutic lumbar facet injections are as follows: (1) no more than one therapeutic intrarticular block is recommended; (2) there should be no evidence of radicular pain, spinal stenosis, or previous fusion; (3) if successful (initial pain relief is 70% plus pain relief of at least 50% for the duration of at least six weeks) the recommendation is to proceed to medial branch diagnostic block and subsequent neurotomy if the medial branch block is positive; (4) no more than two joint levels may be blocked at any one time; (5) there should be evidence of formal plan of additional evidence based activity and exercise in addition to facet joint injection therapy. As far as facet joint medial branch blocks, it is not recommended except as a diagnostic tool and there is minimal evidence for treatment.

It should be noted that the patient does not meet the criteria as outlined by the evidence based ODG for lumbar facet injections. In addition, office visits for the last several years have had minimal physical examination findings and have been mainly for pain medication refills. It has been reported that the patient is disabled and one would assume that he has not returned to any work activity. Dr. in a recent examination on 04/29/09 noted a bilateral straight leg raise to be present, which again is inconsistent with the request for facet injections. The patient is also over six years status post work related injury. Therefore, the

requested lumbar facet injections at L3-L4 and L4-L5 are neither reasonable nor necessary and the previous adverse determinations should be 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 AND KNOWLEDGE BASE
- 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)