

- Adverse Determination Letter dated 2/12/10, 1/13/10.
- Pre-Authorization Request Form dated 2/3/10-3/3/10, 1/8/10-2/8/10.
- History/Physical dated 1/20/10, 1/6/10, 12/2/09.
- Procedure Report dated 11/17/09, 11/12/09, 11/10/09.
- MRI Lumbar Spine dated 7/23/09.

There were no guidelines provided by the URA for this referral.

PATIENT CLINICAL HISTORY (SUMMARY):

Age:

Gender: Male

Date of Injury:

Mechanism of Injury: Not provided.

Diagnosis: Lumbago, lumbar radiculopathy and lumbar herniated disc.

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

This male sustained an injury on xx/xx/xx. The mechanism of injury was not provided. The records indicated that the claimant had a history of back pain with radiculopathy. His diagnoses were lumbago, lumbar radiculopathy and lumbar herniated disc. A lumbar MRI, performed on 07/23/09, showed multilevel degenerative spondylosis and interbody disc protrusion and a L4-5 right central lateral disc protrusion with deformity of the right L5 nerve root sleeve and lateral recess neuroforaminal stenosis. A right transforaminal epidural injection and a right L5 selective nerve root injection were performed on 11/17/09. A physician record, dated 12/02/09, noted that the claimant had complete relief of lumbar and lower extremity radicular symptoms following the injection. It was noted that he was able to return to many of his functions and activities. A 01/06/10 physician record, documented that he reported the development of some lumbar pain over the past two weeks when sitting for extended periods of time. No traumatic event was noted. Lumbar facet blocks for both diagnostic and therapeutic purposes were recommended. A follow up physician record, of 01/20/10, revealed the claimant's lumbar pain had worsened. The diagnosis remained unchanged and noted the claimant with facetogenic pain. Additional injections were recommended. This claimant appeared to have nerve root compression on the MRI. An injection for radiculopathy, in November pf 2009, reportedly brought about an excellent relief of symptoms. The 01/06/10 note suggested positive straight leg raising bilaterally and included the diagnosis of lumbar radiculopathy. The most recent examination still indicated positive straight leg raising.

It was unclear if the claimant had truly failed a thorough course of home exercise, physical therapy, and anti-inflammatories in the management of these complaints. The MRI would suggest multi level degenerative changes and would not localize objective findings at which a two level injection could be directed.

Given these issues, the information provided would not satisfy the MTUS Chronic Pain-Facet injection guidelines.

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

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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.

Official Disability Guidelines (ODG), Treatment Index, 8th Edition (web), 2010, Low Back - Facet joint diagnostic blocks (injections); Facet joint intra-articular injections (therapeutic blocks); Facet joint injections, multiple series. “Criteria for the use of diagnostic blocks for facet mediated pain: Clinical presentation should be consistent with facet joint pain, signs & symptoms. 2. Limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally. 3. There is documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks.”
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).