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Notice of Independent Review Decision

DATE OF REVIEW: 12/03/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar facet injection at L4-L5 and L5-S1

**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 injection at L4-L5 and L5-S1 - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

MRIs of the lumbar and cervical spine interpreted by M.D. dated 12/23/09

MRIs of the knees and shoulders interpreted by Dr. dated 12/24/09
Evaluations with M.D. dated 01/05/10, 02/02/10, 03/22/10, 04/22/10, 05/20/10, 07/02/10, 08/16/10, 09/21/10, 10/21/10, and 11/19/10
X-rays of the cervical spine, lumbar spine, and right shoulder interpreted by Dr. dated 01/05/10
Preauthorization requests – notices of authorization dated 02/15/10, 08/24/10, and 10/29/10
A preauthorization request – notice of non-authorization from M.D. dated 02/26/10
Preauthorization requests – notices of non-authorization from, M.D. dated 03/04/10 and 10/04/10
Procedure notes from Dr. dated 03/12/10, 06/11/10, and 09/07/10
A request for an IRO from Dr. dated 03/18/10
An EMG/NCV study interpreted by, M.D. dated 03/29/10
An IRO report dated 04/08/10
A request for a Contested Case Hearing (CCH) from Dr. dated 04/13/10
Computerized muscle testing (CMT) and range of motion testing dated 04/22/10, 05/20/10, 08/17/10, and 10/21/10
A letter from Ombudsman, dated 04/23/10
A Required Medical Evaluation (RME) with M.D. dated 05/11/10
A preauthorization request – notice of authorization from Dr. dated 05/25/10
A letter of withdrawal for a CCH request from Dr. dated 05/25/10
An order to dismiss medical dispute from dated 05/25/10
A Functional Capacity Evaluation (FCE) with P.T. dated 05/27/10
An order setting a CCH from Ms. dated 07/13/10
A preauthorization request – notice of nonauthorization from M.D. dated 10/11/10
The ODG guidelines were not provided the carrier or the URA

PATIENT CLINICAL HISTORY

An MRI of the lumbar spine interpreted by Dr. on 12/23/09 showed broad-based posterior protrusion-subligamentous disc herniation at L3-L4 and L5-S1. An MRI of the cervical spine interpreted by Dr. on 12/23/09 showed a broad based posterior protrusion-subligamentous disc herniation at C6-C7. An MRI of the right knee interpreted by Dr. on 12/24/09 showed a grade I sprain of the medial collateral ligament (MCL), a bone bruise/bone contusion of the proximal tibia, and a slight joint effusion. An MRI of the left knee

interpreted by Dr. on 12/24/09 showed a grade II sprain of the MCL and slight joint effusion. An MRI of the left shoulder from Dr. on 12/24/09 showed a partial thickness tear of the distal supraspinatus tendon, biceps tendon tenosynovitis, and degenerative arthritis in the AC joint. An MRI of the right shoulder from Dr. on the same date showed a partial thickness tear of the distal supraspinatus tendon, a partial thickness intrasubstance tear of the distal infraspinatus tendon, and slight joint effusion/synovitis. On 01/05/10, Dr. recommended aggressive physical therapy and continued anti-inflammatories. X-rays of the cervical and lumbar spine and right shoulder from Dr. on 01/05/10 were unremarkable. On 02/26/10, Dr. wrote a letter of non-authorization for a lumbar ESI. A cervical epidural steroid injection (ESI) was performed by Dr. on 03/12/10 and 09/07/10. On 03/18/10, Dr. requested an IRO. An EMG/NCV study interpreted by Dr. on 03/29/10 showed moderate diabetic peripheral neuropathy bilaterally, moderate bilateral carpal tunnel syndrome, and mild cubital tunnel syndrome. The IRO on 04/08/10 determined the lumbar ESIs were not medically necessary. On 04/22/10, Dr. recommended a lumbar ESI. On 05/11/10, Dr. recommended ESIs and lumbar facet joint blocks. On 05/20/10, Dr. changed Vicodin ES to Percocet and prescribed an electrostimulator unit. An FCE with Mr. on 05/27/10 indicated the patient functioned at a medium physical demand level and four weeks of work conditioning were recommended. A left L4-L5 and right L5-S1 facet injection was performed by Dr. on 06/11/10. On 07/02/10, Dr. recommended post injection therapy and a second cervical ESI. On 10/06/10, Dr. wrote a letter of non-authorization for lumbar facet injections at L4-L5 and L5-S1. On 10/11/10, Dr. also wrote a letter of non-authorization for the facet injections. On 10/21/10, Dr. again recommended a second set of lumbar facet injections, a psychosocial screening, and cervical surgery. On 11/19/10, Dr. discussed lumbar surgery and continued the medications.

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

The requested lumbar facet injections at L4-L5 and L5-S1 are neither reasonable nor necessary. In the visit of 11/19/10, Dr. appears to be considering decompressive laminectomy for relief of this patient's symptoms. The ODG clearly states that facet joints injections are not recommended for the treatment of radicular pain. Furthermore, the patient had an unusual response to the previous facet injections performed. His pain response was far longer than one would expect from the injection of local anesthetics. This is unlikely to be physiological in nature. Repeating the facet injections is not appropriate at this time. Therefore, the requested lumbar facet injections at L4-L5 and L5-S1 are not reasonable or 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)