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Notice of Independent Review Decision

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 03/01/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Lumbar facet block injection at L4-L5 and L5-S1, fluoroscopic guidance, and anesthesia

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:

X 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 block injection at L4-L5 and L5-S1, fluoroscopic guidance, and anesthesia - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW
An Employer's First Report of Injury or Illness form dated 05/27/09

An evaluation with, D.O. dated 05/27/09
DWC-73 forms from Dr. dated 05/27/09, 05/30/09, 06/09/09, 07/13/09, 07/22/09, and 08/10/09
Evaluations with, M.D. dated 06/09/09, 06/30/09, 07/22/09, and 08/10/09

A physical therapy evaluation with, P.T. dated 06/11/09
Physical therapy with Mr. dated 06/23/09, 06/25/09, 06/30/09, 07/02/09, 07/14/09, 08/06/09, and 08/07/09
An evaluation with, M.D. dated 07/13/09
An MRI of the lumbar spine interpreted by, M.D. dated 07/29/09
DWC-73 forms from, D.C. dated 08/17/09, 09/15/09, 10/22/09, 11/03/09, and 12/30/09
A Functional Capacity Evaluation (FCE) with Dr. dated 08/27/09
An EMG/NCV study interpreted by Dr. dated 09/23/09
Evaluations with, M.D. dated 11/04/09, 12/11/09, and 12/22/09
A preauthorization request from Dr. dated 12/18/09
An evaluation with, P.A. dated 12/22/09
A letter of adverse determination, according to the Official Disability Guidelines (ODG), from, M.D. dated 12/23/09
A letter of adverse determination, according to the ODG, from Dmitry Golovko, M.D. dated 01/05/10
An evaluation with, N.P. dated 01/18/10
A letter from Dr. dated 01/24/10
An IRO Summary dated 02/15/10
The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY

The Employer's First Report of Injury or Illness stated the patient strained multiple body parts from material handling/pulling on xx/xx/xx. On xx/xx/xx, Dr. performed OMT and provided Ibuprofen and Flexeril. Physical therapy was performed with Mr. from 06/23/09 through 08/07/09 for a total of seven sessions. An MRI of the lumbar spine interpreted by Dr. on 07/29/09 showed a very small posterior annular tear at L4-L5 and at L5-S1 with a 3 mm. disc protrusion at L5-S1. Based on an FCE on 08/27/09, the patient was only able to function in the light physical demand level. An EMG/NCV study interpreted by Dr. on 09/23/09 was unremarkable. On 11/04/09, Dr. recommended Ibuprofen, Darvocet-N, Amrix, Neurontin, and lumbar facet injections. On 12/22/09, Ms. performed a Toradol and Norflex injection. On 12/23/09, Dr. wrote a letter of adverse determination for lumbar facet injections. On 01/05/10, Dr. also wrote a letter of adverse determination for lumbar facet blocks.

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

Dr. has not made a convincing case that this individual has facet joint disease. Multiple requests have been made, with his last appeal letter dated 01/24/10 stating the patient would be best treated with intrarticular facet joint injections. It should be noted that the current medical literature has assessed the use of intrarticular facet joint injections as being no better than placebo. The fact that an individual is tender over the facet is a subjective finding and does not confirm facet disease. I have reviewed the current medical literature and there is no scientific evidence that the patient's course would be more rapidly facilitated by the treatment course recommended. The request for lumbar facet block

injections at L4-L5 and L5-S1 under anesthesia and with fluoroscopic guidance would be neither reasonable nor necessary based upon the scientific evidence and the medical records. Therefore, 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**
- 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)**