

# I-Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Nov/17/2010

**IRO CASE #:**

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

One facet injection at the bilateral L4-5 and L5-S1

**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:

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Official Disability Guidelines 2010

09/02/10, 09/27/10

09/02/10, 09/27/10

Dr. 08/25/10

Addendum Dr. 0825/10

Dr. 08/10/10, 09/07/10

X-ray 08/10/10

MRI 07/08/10

Therapy 04/14/10-07/02/10

**PATIENT CLINICAL HISTORY SUMMARY**

The claimant is a male with low back pain after bending over to shake a 5 gallon jug at work in xx/xx. A 07/08/10 MRI of the lumbar spine showed L1-2, 2-3, 3-4 and 4-5 had no facet hypertrophy or ligament flavum thickening. At L5-S1, there was disc desiccation and loss of disc height and a protrusion with no facet hypertrophy or ligament flavum thickening. The claimant was seen by Dr. on 08/10/10 for ongoing low back pain. He had been treated with 12 therapy sessions, Medrol, Flexeril and Skelaxin without help. Celebrex had been of some benefit. Back pain was relieved by rest and lying on stomach. The examination documented normal sensation, normal reflexes, and normal strength. There was negative straight leg raise. Tenderness was appreciated at the lumbosacral junction. Epidural steroid injection was recommended at that time. Dr. dictated an addendum on 08/25/10 to the 08/10/10 visit. In that, it was reported there was tenderness to paravertebral facets. The claimant had decreased motion with pain on lateral flexion and extension and forward flexion for segmental

rigidity. Dr. then requested facet injections at L4-5 and L5-S1 on that basis.

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

In this case, a facet injection at the bilateral L4-5 and L5-S1 is in dispute. Dr. is concerned about facet rigidity and has documented decreased motion and pain on lateral flexion, extension and forward flexion. Tenderness overlying the paravertebral facets is documented. If one looks towards the ODG guidelines, diagnostic criteria for segmental rigidity, axial back pain increased by lateral bending and extension should be present in this case. Pain is elicited with lateral bending and forward flexion.

There should be a confirmed loss of true lumbar extension and/or lateral bend in the presence of intact sacral motion, thus there should be a failure of progression of range of motion with exercise alone. There is no documentation of failure to gain range of motion in therapy. There is no documented loss of lumbar extension or lateral bend with intact sacral motion as decreased motion was documented at one office visit of 08/25/10. As there does not appear to be any loss of extension, there is no documentation whether or not sacral motion is intact and there is no documentation of failure to show range of motion progress with exercise alone, facet rigidity cannot be diagnosed based upon the ODG guidelines and therefore, facet injections at bilateral L4-5 and L5-S1 would not be considered medically necessary absent any facet pathology. The reviewer finds that medical necessity does not exist for One facet injection at the bilateral L4-5 and L5-S1.

**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

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)