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Notice of Independent Review Decision
SECOND AMENDED LETTER

DATE OF REVIEW: October 28, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Bilateral lumbar facet block injections L4-S1.

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

M.D., Board Certified in Orthopedic Surgery.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

[ ] Upheld (Agree)

[X] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

Bilateral lumbar facet block injections L4-S1 are medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization dated 10/5/10.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 10/5/10.
3. TDI Notice of Assignment of Independent Review Organization dated 10/8/10.
4. TDI Notice to IRO of Case Assignment dated 10/8/10.

5. Letter from Pain Management Center dated 8/25/10.
6. Office Notes from Pain Management Center dated 8/9/10 and 9/8/10.
7. Letter of Medical Necessity from DO dated 8/19/10.
8. Follow-up Consultation Notes from Advanced Invasive Pain Management dated 7/19/10 and 8/16/10.
9. Texas Workers' Compensation Work Status Report dated 7/31/10.
10. Designated Doctor Evaluation dated 7/31/10.
11. Precertification/Referral Request dated 8/9/10.
12. Test results from Diagnostics, LLC dated 9/8/10.
13. Physical Medicine Evaluation dated 5/17/10.
14. Follow-up WC Visit from Medical Center dated 5/10/
15. Radiology Report – Lumbar MRI from Imaging dated 12/10/09.
16. Letter from dated 10/13/10.
17. Denial Documentation.

PATIENT CLINICAL HISTORY [SUMMARY]:

A male patient has requested authorization and coverage for bilateral lumbar facet blocks. The Carrier has denied this request indicating that the requested service is not medically necessary for treatment of the patient's low back pain.

A review of the record indicates the patient was originally injured on xx/xx/xx. The patient was treated with conservative care including physical therapy and TENS unit. He has had structured physical therapy and has engaged in a home exercise program. The patient has had back pain on provocative physical exam and has taken hydrocodone for his back pain. An MRI of the lumbar spine dated 12/10/09 revealed broad-based disc herniation at L5-S1 and disc herniation at L4-5, as well as facet joint effusions. EMG nerve conduction studies performed on 8/13/10 revealed right L4-5 radiculopathy and a mild motor axonal neuropathy. The patient's provider has recommended lumbar facet joint injections L4-S1 for the patient.

The Carrier indicates the requested service is not medically necessary. According to the Carrier, the submitted documentation does not support signs and symptoms of facet syndrome. The Carrier states the patient has documented lumbar herniation on MRI with a positive straight leg test and mention of multiple pain generators. The Carrier further indicates there is not a clear treatment plan demonstrating the reason for the proposed facet blocks.

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

Bilateral lumbar facet block injections L4-S1 are medically necessary for this patient. The submitted medical record documentation demonstrates that he has had an adequate trial of conservative care since his date of injury on xx/xx/xx . The Official Disability Guidelines (ODG) – Lumber Chapter states the diagnostic criteria for segmental rigidity. This patient fits the criteria for this diagnosis. The recommendation for segmental rigidity includes facet blocks.

It is well established in the orthopedic spinal literature that the disc associated with backache is L4-5. It has been shown that any pathology at that level has forced transmissions to the adjacent facets (L3-4 and L5-S1). In addition to meeting ODG criteria, the request for facet block injections is in accordance with accepted medical standards within the orthopedic/spinal community. As such, the requested bilateral lumbar facet block injections L4-S1 are medically necessary for this patient's condition.

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 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

[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)