

# I-Decisions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Oct/16/2010

**IRO CASE #:**

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

Facet Block, Lumbar

**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

Services Corporation 08/31/10 and 09/21/10

MRI left knee report 07/08/10

06/07/10 and 08/24/10 Computerized Muscle Testing.

02/07/09, 02/16/09 office notes

MRI lumbar spine reports 08/12/09, 02/16/10

09/08/09 Dr. DDE

10/26/09 Dr. DDE

Office notes of Dr., 02/03/10, 03/03/10, 03/31/10, 04/28/10

Dr. 02/25/10

Dr. peer review

Office notes of Dr., 06/07/10, 07/15/10, 08/24/10, 08/16/10

**PATIENT CLINICAL HISTORY SUMMARY**

This is a female with complaints of mechanical low back pain that has been treated with physical therapy, chiropractics, pain management and medication. The MRI of the lumbar spine, dated xx/xx/xx , showed no evidence of herniated disc, spinal stenosis or neural foraminal narrowing, normal articular facets. It was noted that the only questionable abnormal finding was mild dehydration and desiccation in the L3-4 disc. On 02/03/10, Dr. noted that the electromyography was negative. The MRI of the lumbar spine, dated 02/16/10, revealed a 2 millimeter diffuse disc bulge at L3-4 with no abnormal enhancement or enhancing lesion. AP and lateral views of the lumbar spine showed no acute compression fracture, listhesis or lytic

or blastic lesion. Mild spondylosis was noted, focal more at the L3-4 with small anterolateral osteophytes with focal mild reduction of this third degree space was reported. There were mild facet arthropathies bilaterally from L3-4 through L5-S1. On 02/25/10, Dr. placed the claimant at maximum medical improvement. On 04/22/10, Dr. recommended no further treatment due to any objective findings. Dr. began treating the claimant in June of 2010. On 8/24/10, Dr. saw the claimant. Examination revealed decreased range of motion and tenderness to the lumbar spine. Diagnosis was mechanical back pain at L3-4 and facet syndrome. Dr. has recommended a facet injection at L3-4.

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

The 08/09 MRI in this case specifically suggested normal articular facets. A treating physician in 02/10 specifically reviewed the MRI and indicated that it was "negative." The 02/10 MRI was interpreted as revealing three different levels of mild facet arthropathy. This MRI did not specifically localize this arthropathy to a single level. It is noteworthy that more recent complaints would appear radicular with documentation of lower extremity pain, numbness and tingling as well as allegedly positive straight leg raising, reportedly diminished reflexes unilaterally. If one turns to the ODG Guidelines regarding facet joint findings and signs, one would expect the absence of radicular findings in a normal straight leg raising examination; which would not appear to be so in this case. If one turns to the ODG Guidelines regarding the criteria for use of diagnostic facet blocks, the radicular component of these complaints would be a contraindication. In short the guidelines are not satisfied for medical necessity regarding the proposed L3-4 facet blocks. The reviewer finds there is no medical necessity for Facet Block, Lumbar.

#### **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)**