



## Medwork Independent Review

5840 Arndt Rd., Ste #2  
Eau Claire, Wisconsin 54701-9729  
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*NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION*  
*Workers' Compensation Health Care Non-network (WC)*  
*MEDWORK INDEPENDENT REVIEW WC DECISION*

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**DATE OF REVIEW: 09/16/2010**

**IRO CASE #:**

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

Lumbar facet injection at bilateral L4/5

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

Texas State Licensed MD Board Certified Anesthesiology & Pain Management physician

**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.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Texas Dept of Insurance Assignment to Medwork 08/30/2010
2. Notice of assignment to URA 08/25/2010
3. Confirmation of Receipt of a Request for a Review by an IRO 08/25/2010
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 08/16/2010
6. HDI letter 08/25/2010, 08/24/2010, 08/05/2010, 07/30/2010, 07/10/2010, AMR 03/01/2010, HDI letter 02/03/2010, 01/27/2010, review 01/18/2010, HDI letter 01/15/2010, 12/09/2009, 09/09/2009, 06/01/2009
7. Medical note 07/26/2010, 06/25/2010, 05/26/2010, 04/26/2010, 03/26/2010, 02/26/2010, 01/22/2010, 01/20/2010, 01/11/2010, 12/15/2009, 12/02/2009, 11/30/2009, 11/18/2009, 11/10/2009, 11/09/2009, 10/23/2009, 10/09/2009, 10/07/2009, 09/10/2009, 09/01/2009, DD exam 08/31/2009, 08/05/2009, 07/06/2009, 06/15/2009, 06/01/2009, 05/26/2009, 05/21/2009, 05/18/2009, 05/14/2009, 05/12/2009, 05/11/2009, 05/05/2009, 05/01/2009, 04/29/2009, 04/21/2009, 04/20/2009, 04/08/2009, therapy 04/2009, note 03/31/2009, 03/23/2009, 03/19/2009, 03/12/2009, 03/10/2009, 02/03/2009, forms/TDI 01/11/2010, 01/10/2009, 11/30/2009, 11/10/2009, 09/01/2009, 08/31/2009, 08/19/2009, 08/05/2009, 07/27/2009, 06/15/2009, 05/11/2009, 04/22/2009, 04/21/2009, 04/08/2009, 03/31/2009, 03/23/2009, 03/12/2009, 03/10/2009, 03/19/2009, 03/12/2009, 03/10/2009, 03/09/2009
8. ODG guidelines were not provided by the URA

**PATIENT CLINICAL HISTORY:**



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A female who sustained a work-related injury on xx/xx/xx, involving the lumbar spine while trying to assist a 350-pound patient who was falling to the floor; claimant tried to break her fall injuring lumbar spine. This claimant has had a prior history of L5-S1 fusion. Claimant is complaining of back pain with radiation to the hips. CT scan of the lumbar spine was performed, revealed far left lateral disk herniation at L4-5 level, foraminal stenosis with localized facet and ligamentous hypertrophy; mild disk bulging at L3-4 level, and postoperative changes with hardware at L5-S1 level. EMG/nerve conduction study performed, revealed chronic bilateral lumbosacral radiculopathy. The claimant has had conservative treatment consisting of physical therapy, medication management, use of a TENS unit, and sacroiliac joint injections; all with unstained pain relief. Current medication profile consists of Tegretol/Elavil (for patient's history of bipolar disorder), Xanax (anxiety), Flexeril, Neurontin, and Tramadol. Lumbar MRI performed, revealed a 3 to 4 mm broad-based posterior disk protrusion at L4-5 level with slight impression on the anterior aspect of the thecal sac, with asymmetric extension of disk and spur into the left neuro foramen causing narrowing with a focal region of disk appearing to contact the left L4 nerve root within the foramen. Paracentral disk cages were noted at L5-S1 level. There was a slight retrolisthesis of L3 on L4 with 3 mm broad-based posterior disk protrusion without central canal or foraminal stenosis. Evaluation performed states that the claimant's extensive injury involved the lumbar spine with disc herniation with foraminal stenosis on the left and a resultant radiculopathy. Records say that the patient placed at maximal medical improvement with a 10% whole person impairment rating. Additional diagnostic testing in the form of lumbar discography was denied in February 2010 secondary to lack of medical necessity. Request is for lumbar facet injection at bilateral L4/5.

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

The Official Disability Guidelines (ODG) criteria for diagnostic facet joint blocks indicate clinical presentation should be consistent with facet joint pain, signs, and symptoms.

1. One set of diagnostic medial branch blocks is required with a response of greater than 70%. The pain response should be approximately 2 hours for lidocaine.
2. Limited to patients with low back pain that is nonradicular and no more than 2 levels bilaterally.
3. There is documentation of failure of conservative treatment including home exercise, physical therapy, and NSAIDs prior to the procedure for at least 4 to 6 weeks.
4. No more than 2 facet levels are injected at one session.

From the documentation it appears to be non-correlating clinical examinations in reference to this patient's lumbar facet joints as being a pain generator. Claimant's pain ratings and reported symptoms are out of proportion to objective physical findings that are documented in the medical records provided. Therefore, the based on information reviewed and the ODG guidelines, there does not appear to be a reasonable suspicion for lumbar facet joint pain. There was no physical examination documenting facet joint provocative maneuvers. Lumbar MRI did not reveal any facet joint hypertrophy or facet problems. The insurer's denial for the requested lumbar facet injection at bilateral L4/5 is upheld.



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### 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 KNOWLEDGBASE
- 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)