

MAXIMUS Federal Services, Inc.
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Notice of Independent Review Decision

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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: February 1, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar facet injection at L5-S1.

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

M.D., Board Certified in Physical Medicine and Rehabilitation.

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)

The requested service, lumbar facet injection at L5-S1, is medically necessary for treatment of the patient's medical condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who sustained a work injury to her lumbar spine and sacroiliac joint on xx/xx/xx while lifting. The patient noted numbness and tingling in both lower extremities. An MRI performed in December 2009 revealed disc space narrowing with broad-based annular bulge and mild facet arthropathy at L5-S1 without stenosis or nerve root compromise and mild bilateral facet arthropathy at L4-5. The patient continued to be on full duty status until she changed treating doctors. She was continued on therapies. Electromyography (EMG) studies performed in September 2010 were unremarkable for lumbar radiculopathy and peripheral entrapment syndromes. The patient underwent right sacroiliac joint steroid injection on 9/10/10. On 9/20/10, the patient's provider reported that physical therapy would be initiated. On 10/18/10, the provider noted tenderness in the patient's lumbar spine and right sacroiliac joint with mildly positive straight leg raising on the right and weakened strength globally in the right lower extremity compared to the left. On 11/29/10, the patient reported significant relief following the sacroiliac joint injection. The provider has recommended lumbar facet injection at L5-S1. A designated doctor diagnosed the patient with lumbar strain/sprain but did not consider her to be at maximum medical improvement (MMI). The URA indicates the requested service is not medically necessary. The URA states that given the patient's multiple pain generators, lumbar facet injection at L5-S1 is not likely to be of significant benefit.

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

Upon review of the submitted clinical evidence and relevant practice guidelines, I have determined that the requested service, lumbar facet injection at L5-S1, is medically necessary for treatment of the patient's medical condition. The patient sustained an on-the-job injury to her low back in xx/xx. She was treated with medications and therapies. She was off work briefly but returned to work with pain. She had diagnostic tests including a lumbar MRI which did not identify any compromised nerves but did identify facet arthropathy. An EMG did not identify any compromised nerves. The patient was taken off work and treated with medications and therapies without significant resolution of her pain. She was treated with a sacroiliac joint injection with cortisone and achieved 60% relief of pain, however, the relief was not sustained. The patient's treating physician requested the facet joint injection as another method of treating her pain as well as to help identify the source of her pain. The Official Disability Guidelines (ODG) allows for at least one facet block in an effort to help identify the source of pain and to treat the pain generator. Given the findings of facet arthropathy, the administration of lumbar facet injection at L5-S1 is consistent with

ODG criteria and is medically appropriate and indicated for this patient.

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
- 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)