

MAXIMUS Federal Services, Inc.  
11000 Olson Drive, Suite 200  
Rancho Cordova, CA 95670  
Tel: [800] 470-4075 Š Fax: [916] 364-8134

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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:** December 20, 2010

**IRO CASE #:**

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

Bilateral lumbar facet blocks at L4-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)

## **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Request for a Review by an Independent Review Organization dated 11/15/10.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 11/29/10.
3. TDI Notice to IRO of Case Assignment dated 11/30/10.
4. Medical records from dated 10/20/10 and 9/20/10.
5. Medical records from Emergency Center dated 8/25/10, 8/20/10, 8/16/10, 8/10/10 and 7/28/10.
6. MRI of the Lumbar Spine dated 10/11/10.
7. Texas Workers' Compensation Work Status Reports.
8. Letter MD dated 10/25/10.
9. Denial documentation.

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female who sustained a work injury on xx/xx/xx. The patient fell on her buttocks and had immediate pain. She complains of low back pain that radiates into the left lower extremity as well as tailbone pain. The patient's provider indicates that when the patient abducts her legs, she feels a popping sensation in the sacral region. The provider states that the patient has continued with physical therapy and all other more conservative modalities have been attempted but nothing seems to help with the overall pain. An MRI performed on 10/11/10 showed mild to moderate disc bulge with effacement of the ventral thecal sac at L5-S1, disc bulging measures approximately .4cm. The patient's provider recommended bilateral lumbar facet blocks at L4-S1. The Carrier indicates the requested services are not medically necessary. According to the Carrier, the patient does not meet criteria for use of therapeutic lumbar facet blocks.

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

The requested treatment of bilateral lumbar facet blocks at L4-S1 is not medically necessary for this patient. The proposed treatment will not address the radicular type of pain experienced by the patient. According to the Official Disability Guidelines (ODG) criteria for therapeutic intra-articular injections/blocks, the ODG states the treatment is "under study" and there is conflicting evidence as to efficacy of this procedure. Furthermore, the use of therapeutic lumbar facet blocks for treatment of coccyx pain is not supported by peer-reviewed evidence. This patient has radicular low back pain and coccyx pain, and thus, the proposed L4-S1 requested facet blocks are not indicated in this setting. All told, the proposed bilateral lumbar facet blocks at L4-S1 are not medically necessary for treatment of the patient's low back and tailbone pain.

## **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)