



Notice of Independent Review Decision

IRO REVIEWER REPORT – WC NETWORK

DATE OF REVIEW: 10/14/11

IRO CASE #: 37181

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right Lumbar Facet Injections at L3-L5

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

Board Certified in Physical Medicine & 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)

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.

Right Lumbar Facet Injections at L3-L5 – UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Lumbar Spine MRI, M.D., 03/04/11
- Evaluation, D.O., 05/06/11, 05/16/11, 08/08/11

- Pre-Authorization, Associates of Central Texas, 05/06/11, 08/03/11, 08/10/11
- Electrodiagnostic Studies, Dr. 05/16/11
- Operative Report, Dr. 05/23/11
- Follow Up, M.D., 06/09/11, 07/11/11
- Follow Up Rehab Evaluation, D.C., 06/14/11
- Denial Letters, 08/12/11, 09/15/11
- Appeal, Associates of Central Texas, 08/17/11

PATIENT CLINICAL HISTORY [SUMMARY]:

The records available for review document that the date of injury was listed as 01/04/11.

It was documented that a lumbar MRI was obtained on 03/04/11. The study disclosed findings consistent with a moderate focal left paracentral disc herniation at the T11-T12 level with mild- to-moderate left neuroforaminal narrowing and effacement of the left anterior lateral thecal sac. Additionally, there was evidence for mild-to-moderate multilevel disc protrusion at the L5-S1, L4-L5, and L3-L4 disc levels.

The patient received an evaluation with Dr. on 05/06/11. On that date, it was recommended that the claimant receive access to treatment in the form of a lumbar epidural steroid injection. It was documented that the patient was with symptoms of low back pain with radiation to the lower extremities. The left lower extremity was more severely affected than the right lower extremity. On physical examination, it was documented that there was a positive straight leg raise test on the left. It was also noted that there was weakness in the left extensor hallucis longus muscle.

Dr. evaluated the patient on 05/16/11. On that date, it was noted that there was a positive straight leg raise test on the left. There was also documentation of 4/5 strength with testing of the left extensor hallucis longus muscle.

An electrodiagnostic assessment was obtained on 05/16/11. The study was obtained on each lower extremity. The study revealed no findings worrisome for a peripheral neuropathy, lumbar radiculopathy, or a myopathy.

A lumbar epidural steroid injection was performed by Dr. on 05/23/11.

The patient was evaluated by Dr. on 06/09/11. It was documented that treatment in the form of a lumbar epidural steroid injection, which had been recently provided to the patient, did result in a significant reduction in pain symptoms. It was noted that the patient was with resolution of pain in the left lower extremity, but there was documentation of right lower extremity pain. It was recommended that the patient partake in light duty work activities.

The patient was evaluated by Dr. on 06/14/11. It was documented that the patient was with symptoms of pain in the right thigh and left thigh. It was recommended that the

patient receive access to treatment in the form of six sessions of physical rehabilitation services.

Dr. re-assessed the patient on 07/11/11. It was noted that treatment in the form of a lumbar epidural steroid injection, which was provided to the patient on 05/23/11, resulted in a significant reduction of pain symptoms.

On 08/08/11, Dr. evaluated the claimant. It was noted that previous treatment in the form of a lumbar epidural steroid injection “completely resolved” symptoms. There were no neurological deficits noted to be present on physical examination.

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

Based upon the records available for review, per the criteria set forth by the Official Disability Guidelines, treatment in the form of right-sided lumbar facet injections would not be supported as a medical necessity. The records available for review document that in the past, there were findings consistent with a lumbar radiculopathy with respect to documented symptoms and physical examination findings. Additionally, it is documented that an attempt at a lumbar epidural steroid injection provided to the patient on 05/23/11 did result in a significant reduction of pain symptoms. Per the criteria set forth by the Official Disability guidelines, the medical necessity for treatment in the form of lumbar facet injections is not established if there are documented radicular symptoms, which would appear to be the case for the described medical situation. As a result, in this particular case, per the criteria set forth by the above noted reference, the submitted medical documentation is not sufficient to support a medical necessity for treatment in the form of lumbar facet injections.

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)**
- AMA 5TH EDITION**