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## Notice of Independent Review Decision

### Reviewer's Report

**DATE OF REVIEW:** April 24, 2012

**IRO CASE #:**

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

Lumbar facet block injections @ bilateral L5-S1 (64493); anesthesia; and fluoroscopic guidance.

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

M.D., Board Certified in orthopedic surgery.

### **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 lumbar facet block injections @ bilateral L5-S1 (64493) are medically necessary for treatment of the patient's medical condition.

The requested fluoroscopic guidance is medically necessary for treatment of the patient's medical condition.

The requested anesthesia is not medically necessary for treatment of the patient's medical condition.

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

1. Request for a Review by an Independent Review Organization dated 4/2/12.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 4/3/12.

3. Notice of Assignment of Independent Review Organization dated 4/4/12.
4. Letter from dated 3/8/12.
5. Patient medical records from dated 6/11/11.
6. Patient medical records from dated 6/15/11 through 3/22/12.
7. Patient medical records from dated 6/22/11 and 10/28/11.
8. Patient medical records from dated 7/11/11.
9. Patient medical records from dated 7/27/11 and 11/11/11.
10. Patient medical records from dated 7/28/11 through 1/26/12.
11. Denial documentation.

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

The patient is a male who sustained a work related injury to his lower back on xx/xx/xx when he tripped and fell. The patient also has been diagnosed with diabetes and hypertension. The patient is noted to have pain with extension of the lumbar spine. The provider indicated, in his letter dated 3/8/12, there is tenderness to deep palpation over the patient's L5 and S1 facet joints bilaterally, with no nerve root tension signs. The patient has undergone conservative treatment with physical therapy and medication. An MRI performed on 7/11/11 revealed the patient to have straightening of the normal lumbar lordosis suggestive of muscle spasm. The patient is requesting authorization for facet joint injections at L5-S1 bilaterally with fluoroscopic guidance under sedation. The Carrier has denied this request indicating that the requested services are not medically necessary for treatment of the patient's low back pain. The Carrier's denial is the subject of this review.

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

Given the patient's symptoms he meets the Official Disability Guidelines (ODG) criteria for facet joint blocks injections. Consistent with ODG criteria, the patient presents with signs and symptoms of facet joint pain. In addition, his pain is limited to non-radicular low back pain and is not present at more than two levels. Further, there is documentation of failure of conservative treatment for at least four to six weeks. Therefore, the request for bilateral facet joint injections at L5-S1 meets ODG criteria and is medically necessary. The use of fluoroscopic guidance during the injections is medically appropriate and necessary. However, there is no indication in the ODG that anesthesia would be appropriate in this patient's clinical situation. In fact, the ODG specifically indicates that sedatives should not be provided during facet joint blocks. Thus, the requested sedation during the bilateral facet joint injections is not medically necessary.

Based upon the information set forth above, I have determined the following:

The requested lumbar facet block injections @ bilateral L5-S1 (64493) are medically necessary for treatment of the patient's medical condition;

The requested fluoroscopic guidance is medically necessary for treatment of the patient's medical condition;

The requested anesthesia is not medically necessary for treatment of the patient's medical condition.

**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)