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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jul/19/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Initial Lumbar Facet Joint Injection Bilateral L5-S1 (including the L5 pars defect) and X-ray Lumbar (L1-S1)

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

MD, Board Certified in Anesthesiology/Pain Management

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 medical necessity exists for each health care service in dispute.

The reviewer finds that medical necessity does not exist for Initial Lumbar Facet Joint Injection Bilateral L5-S1 (including the L5 pars defect) and X-ray Lumbar (L1-S1).

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Utilization review determination 03/26/12

Utilization review reconsideration 04/13/12

Designated doctor evaluation 06/05/12 and 02/07/12

Pre-authorization reconsideration request 04/11/12

Clinical assessment 02/21/12

Pre-authorization initial request 03/21/12

Spec/CT bone imaging 12/02/11

Progress note 02/03/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who injured his low back on xx/xx/xx while lifting a battery weighing approximately 85 pounds. The claimant states he felt a pop in his back and had immediate low back pain. Records indicate the claimant was treated conservatively with physical therapy and medications. The claimant was allowed to return to work with restrictions, but the employer declined to have him work with those restrictions. Spec/CT bone imaging on 12/02/11 demonstrated bilateral spondylolysis at L5-S1 and grade 1 spondylolisthesis. There was no abnormal uptake in the posterior elements at the level of the lysis. Physical examination by Dr. on 02/03/12 reported reflexes were normal at the bilateral knees and ankles. There was no clonus. Sensation was normal in all dermatomes. Romberg test was normal. The claimant demonstrated good heel/toe walk. There was antalgic gait favoring the right side. Straight leg raise on the left caused low back pain in the midline, and straight leg raise on the right caused low back pain in the midline. It was noted that low back and right leg pain seemed to have worsened and physical therapy is not doing much to improve his pain. Consideration was for referral to pain management specialist for epidural steroid

injections near the pars defect to rule out that area as a pain generator. The claimant was seen by Dr. on 02/21/12 with complaints of an axial lumbosacral area pain radiating up to the lumbar spine right and left equally. The claimant also complained of right leg pain which refers deep down into the leg and down to the knee and sometimes radiates all the way to the right foot.

Examination reported negative slump test/straight leg raise. Femoral stretch was negative. Deep tendon reflexes were absent at the knees, 1/4 at the ankles. Motor strength was 5/5 throughout the bilateral lower extremities. Sensation was normal in the lower extremities. Prone lumbar exam reported spring maneuver positive LS junction, mid lumbar. There is paramedian tenderness at the LS junction bilaterally, and mid lumbar bilaterally. Sacral thrust was positive.

A request for bilateral L5-S1 facet joint injections was denied by utilization review dated 03/26/12. Noting there is documentation of pain symptoms with radicular features.

A reconsideration request for bilateral L5-S1 lumbar facet injections was denied by utilization review dated 04/13/12 noting that x-ray was denied because there is high likelihood one has already been done as the patient had MRI and bone scan.

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

This claimant has had advanced imaging including MRI and bone scan. It was noted doctors at Concentra previously ordered x-rays, and it is likely these were done although no report was provided. It is noted the claimant has findings consistent with lumbar radiculopathy. Per ODG guidelines, lumbar facet / medial branch blocks should be reserved for patients with low back pain that is non-radicular in nature and no more than 2 levels bilaterally. There also should be documentation of failure of conservative treatment including home exercise program, physical therapy, and NSAIDs for 4-6 weeks prior to procedure. The patient reportedly has had physical therapy, but no documentation was provided indicating the total number of therapy visits completed or modalities used. Based on the information submitted for review and the evidence-based guidelines not being met, the reviewer finds that medical necessity does not exist for Initial Lumbar Facet Joint Injection Bilateral L5-S1 (including the L5 pars defect) and X-ray Lumbar (L1-S1).

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM-AMERICA 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)