

Prime 400 LLC

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Oct/17/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar Facet Inj w/Fluoro Sed L4-L5, L5-S1 – 64493.50 64494.50 64495.50

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

M.D., Board Certified Anesthesiology; Board Certified 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 the requested Lumbar Facet Inj w/Fluoro Sed L4-L5, L5-S1 – 64493.50 64494.50 64495.50 is not indicated as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
MRI lumbar spine without contrast dated 01/10/11
EMG/NCV dated 07/08/11
Open MRI lumbar spine without contrast dated 09/21/11
Office visit notes Dr. dated 01/12/12
Office visit notes Dr., 01/30/12-03/26/12
Procedure note dated 03/19/12
Handwritten progress notes 04/03/12 and 05/02/12
Office visit notes Dr. dated 06/04/12-09/20/12
Preauthorization form dated 07/05/12
Utilization review determination dated 08/06/12
Utilization review determination dated 09/19/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female whose date of injury is xx/xx/xx. She bent over to pick up a , and as she came back up to the upright she felt a sudden sharp pain in the lower back. The patient completed 12 sessions of physical therapy and 3 weeks of work hardening. MRI of the lumbar spine dated 01/10/11 revealed L1-2, L2-3, L3-4 and L4-5 are normal. At L5-S1 there is high signal in the posterior central annulus reflecting annular tear. There is disc bulge and on the axial images a more focal protrusion centrally which contacts but does not deform the

thecal sac. There is no evidence of impingement upon either S1 nerve root. The spinal canal dimensions remain adequate. AP dimension of the thecal sac is 13 mm. The foramina are adequate. EMG/NCV dated 07/08/11 revealed no evidence of lumbosacral radiculopathy. MRI of the lumbar spine dated 09/21/11 revealed a 3 mm central disc protrusion at L5-S1 with a zone of hyperintensity on T2. No canal stenosis or neural foraminal encroachment is appreciated. There is no facet hypertrophy or ligamentum flavum thickening. The patient underwent lumbar epidural steroid injection on 03/19/12. Note dated 06/04/12 states that the patient underwent diagnostic facet blocks with only temporary relief. The most recent follow up note dated 07/26/12 states that the patient is more active and is walking with greater ease. She is more functional. She still has exquisite tenderness over the lumbar facet regions at L4-5 and L5-S1 aggravated with side bending and extension but she states it is bearable now.

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

The note dated 06/04/12 clearly states, "she apparently received a single lumbar epidural block as well as diagnosis facet blocks with only temporary relief". The next note dated 06/18/12 states that the patient is still having some spasms and leg pain consistently with herniated disc and lumbar radiculopathy. The submitted MRI notes that there is no facet hypertrophy or ligamentum flavum thickening at L4-5 and L5-S1. There is no clear rationale provided to support another lumbar facet injection when the initial injection provided only temporary relief. The patient reportedly presents with lumbar radiculopathy. The Official Disability Guidelines note that facet injections are limited to patients with low back pain that is non-radicular. There is no clear rationale provided to support the use of sedation as there is no documentation of extreme anxiety or needle phobia. The reviewer finds the requested Lumbar Facet Inj w/Fluoro Sed L4-L5, L5-S1 – 64493.50 64494.50 64495.50 is not medically necessary.

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)**