

Clear Resolutions Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/29/2012

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Bilateral Facet Injections L4-5 and L5-S1; right-sided SI injection

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

M.D., Board Certified 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. It is the opinion of the reviewer that medical necessity is not established for Bilateral Facet Injections L4-5 and L5-S1; right-sided SI injection.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Utilization review determination dated 06/26/12, 07/09/12

Office visit note dated 08/01/12, 07/18/12, 06/27/12, 06/20/12, 06/13/12, 05/24/12, 05/23/12

Reconsideration letter dated 06/27/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male whose date of injury is xx/xx/xx. He stepped off a 3-foot retaining wall and felt a pop and low back pain. He has had two epidural steroid injections, diagnostic testing (no reports submitted for review), physical therapy, 2 months of daily work hardening and medication management. Injection consultation dated 06/20/12 indicates that lumbar MRI documents multilevel degenerative changes from L4-S1, but no additional nerve compression was noted. Electrodiagnostic testing was reportedly negative for radiculopathy. The patient has completed 4 of 10 visits of functional restoration program and is making good progress, but this progress is noted to be limited somewhat by lack of lumbar motion. The patient was recommended for lumbar facet injection trial. On physical examination lumbar motion is extension to neutral, side bending 5 degrees bilaterally, forward flexion 50 degrees. There is diffuse posterior lumbar tenderness, most pronounced over the low lumbar facet joints. There is an associated positive right PSIS tenderness, but no significant tenderness over the left PSIS. Quadrant load is positive bilaterally, right greater than left. Prone straight leg raising is similarly positive. Supine straight leg raising is negative for radiculopathy symptomatology, but reproduces back pain. Lasegue's sign is negative. Deep tendon reflexes are 2/4 and symmetric in the lower extremities. Motor power is 5/5. Sensation is well-preserved in the lower extremities. The request for facet and SI injections was denied on 06/26/12. The patient had facet injections before with no indication of response, but the fact that radiofrequency ablation was not done indicates the result was not significant. Therefore, repeat facets, even if for a new diagnosis of "segmental rigidity" are not needed. The sacroiliac joint injection is denied based on lack of provocative sacroiliac maneuvers

documented. Reconsideration letter dated 06/27/12 indicates that the patient has positive Fortin's finger sign, and prone straight leg raising quadrant load is positive to sacroiliac joint. The denial was upheld on appeal dated 07/09/12 noting that current evidence based guidelines state that SI joint injections should be performed when diagnostic evaluation has first addressed any other possible pain generators.

The concurrent request for facet injections indicates that other possible pain generators have not been addressed. ODG notes that SI joint injections should not be performed on the same day as facet joint injections. The patient is currently enrolled in a chronic pain management program, which is a tertiary level program. This indicates that the patient was determined to have exhausted lower levels of care prior to enrollment in the program. The patient is reported to have undergone previous facet injections; however, the patient's objective, functional response is not documented. The submitted physical examination notes only positive Fortin's finger sign. Current evidence based guidelines require at least 3 positive exam findings prior to the performance of an SI joint injection.

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

The patient has reportedly undergone previous facet injections; however, there are no procedure reports submitted for review documenting the dates and levels of these injections, and the patient's response to the procedures are not provided. The patient was previously enrolled in a chronic pain management program. Patients who participate in chronic pain management programs have been determined to have exhausted lower levels of care prior to participation in these tertiary level programs. The patient's physical examination does not document at least 3 positive exam findings to establish the presence of sacroiliac joint dysfunction. It is the opinion of the reviewer that medical necessity is not established for Bilateral Facet Injections L4-5 and L5-S1; right-sided SI injection.

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)