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IRO Certificate #4599

### Notice of Independent Review Decision

DATE OF REVIEW: 11/19/13

IRO CASE NO.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE  
Facet Injection @ L4/L5, L5/S1, Bilateral. CPT: 64493, 64491

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION  
Physician Board Certified Pain Management & Anesthesiology

#### REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

|                     |  |
|---------------------|--|
| <b>Upheld</b>       | <b>(Agree) <input checked="" type="checkbox"/></b> |
| Overtured           | (Disagree)   |
| Partially Overtured | (Agree in part/Disagree in part)                   |

#### INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letter, ODG attached: Worker's Compensation Svcs., 8/13/13  
Appeal, with ODG attached: Worker's Compensation Svcs., 9/19/13  
Peer to Peer Review, 5/30/13

**Clinic Notes include:** pain diagrams, office visits, back pain questionnaire, 10/25/13-3/07/13; follow-up letter re denial, 8/20/13

Exam: MRI Lumbar Spine w/o contrast, 2/27/13

Physical Therapy Notes include: Visit History, Therapy re-assessment, therapy progress, 2/18/13-1/17/13

Operative Procedure: Lumbar facet injections, L4 to S1 Bilateral, 4/02/13

ODG (Official Disability Guidelines)

#### PATIENT CLINICAL HISTORY SUMMARY

This female sustained a low back injury in xx/xxxx, while pulling on a door, and twisting. There is persistent low back pain. Physical therapy and medications have been provided. Her medications include Celebrex, Ultracet, Zanaflex, and Lyrica. A physical examination revealed pain and tenderness over the L4-5 and L5-S1 joints, pain produced by flexion and extension. An MRI from 2/27/13 showed a small disc protrusion in L4-5, and a right facet joint effusion was present. A bilateral lumbar facet injection at L4-5 and L5-S1 was performed on 4/02/13. Xylocaine was injected into each joint. There is no indication that steroids were utilized.

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

##### **Decision:**

I agree with the benefit company's decision to deny the requested service.

**Rationale**

ODG require 50 to 80% pain relief for the duration of the local anesthetic after facet blocks. There was no documentation of pre-procedure or post-procedure pain levels. A prior radio frequency procedure was requested and denied since there was no documentation of pain relief from the immediate pain relief from the previous facet injections. Repeating facet injections are not endorsed by ODG. A single diagnostic injection is indicated which was performed but there was no documentation of pre and post procedure pain levels; therefore, ODG are not met for repeating the facet injection

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

ACOEM-AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL  
MEDICINE UM KNOWLEDGE BASE

AHCPR-AGENCY FOR HEALTH CARE 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 & EXPERTISE IN ACCORDANCE WITH  
ACCEPTED MEDICAL STANDARDS X**

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

**ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES X**

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 DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES  
(PROVIDE DESCRIPTION)