

P-IRO Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Mar/19/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Bilateral facet joint injections at L4-5-S1

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

PM&R and Pain Medicine

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Physical therapy reports 11/03/08-03/24/10 and 07/26/10
MRI lumbar spine 11/15/08
MRI lumbar spine 02/18/10
MRI lumbar spine 07/01/10
MRI lumbar spine 04/27/11
Psychological evaluation 11/09/11
Clinical notes 10/22/08-02/12/13
Procedure note 12/02/08
Radiographs lumbar spine 12/24/08
Procedure note 04/17/09
Operative report 03/08/10
Operative report 01/03/12
Prior reviews 02/18/13 and 02/25/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an injury on xxxxx and was followed for post-laminectomy syndrome following a left sided hemilaminectomy and discectomy on 03/08/10. The patient underwent spinal cord stimulator trial on 01/03/12. Following this trial, the patient had significant response with the spinal cord stimulator and was recommended for a permanent placement. This apparently was performed, although no operative report regarding the permanent placement was submitted for review. The patient reported

continuing benefits from a spinal cord stimulator and was managed with medications including Norco Naprosyn and Lyrica. The patient was seen on 02/12/13 with increasing amounts of low back pain that was not covered by the use of hydrocodone. Physical examination revealed tenderness to palpation over the paravertebral musculature in the lumbar spine. The patient reported pain with range of motion and flexion and extension were restricted. Straight leg raise was positive at 90 degrees. No focal neurological deficits were seen. The patient was recommended for facet injections both diagnostic and for therapeutic purposes at L4-5 and L5-S1. This request was denied by utilization review on 02/18/13 as there were no updated radiographic findings or physical examination findings supporting the possibility of facet mediated pain. The request was again denied by utilization review on 02/25/13 as there was insufficient clinical documentation regarding evidence of lumbar facet disease.

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

Based on the submitted clinical documentation, the requested L4-5 and L5-S1 facet joint injections bilaterally would not be consistent with guideline recommendations. The patient reported an increasing amount of low back pain with paravertebral tenderness on physical examination. There was restricted range of motion, however. There was no clear evidence of facet mediated pain that would reasonably support the requested facet joint injections. There was also no updated imaging study of the lumbar spine identifying significant facet arthropathy that would further support a diagnosis of facet mediated pain. Current evidence based guidelines recommend diagnostic medial branch blocks in the treatment of facet mediated pain; however, and given the limited objective findings supporting a diagnosis of facet mediated pain, they would not be indicated in this case. Additionally, current evidence based guidelines do not recommend therapeutic facet joint injections but instead recommend diagnostic medial branch blocks in order to determine the presence of facet mediated pain that may benefit from further facet rhizotomy. As there is no indication in this case that the patient would proceed with facet mediated facet ablation and as there is insufficient objective evidence regarding facet mediated pain, it is the opinion of this reviewer that medical necessity for the request is not established based on guideline recommendations. As such, the prior denials are upheld.

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

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES