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An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/21/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: bilateral lumbar facet blocks L3-4

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O., Board Certified Orthopedic Surgery

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 this reviewer's opinion that medical necessity for bilateral lumbar facet blocks L3-4 is established and consistent with guideline recommendations.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Clinical reports from Anesthesiology dated 01/16/12 – 04/03/12

Procedure reports dated 01/24/12 & 02/22/12

Physical therapy reports dated 06/08/11 – 04/23/12

Electrodiagnostic studies dated 09/22/11

CT of the cervical, thoracic, and lumbar spine dated 03/18/11

Radiographs of the cervical spine dated 03/22/13

Radiographs of the lumbar spine dated 05/01/13

Clinical reports dated 02/28/12 – 05/08/13

Clinical report dated 06/05/13

Letter dated 06/28/13

Letter of appeal dated 07/18/13

Prior reviews dated 06/20/13 & 07/11/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who sustained an injury on xx/xx/xx. The patient is noted to have undergone a prior cervical fusion at C5-6 and C6-7. The patient has also been followed for complaints of low back pain following a fusion at L4-5. Prior CT studies from 03/18/11 did show facet joint spurring and facet joint hypertrophy to the right at L3-4. The most recent radiograph studies of the lumbar spine completed on 05/01/13 again showed mild degenerative changes within the facets at L3-4 as well as disc space narrowing. The patient was noted to have had hardware removal at L4-5 and continued to report low back pain. The patient was recommended to consider therapy for the neck and back in February of 2013. On 05/01/13, the patient reported hearing a large pop in the low back with radiating pain through the lower extremities, right worse than left. Physical examination demonstrated good range of motion in the lumbar spine. The patient could perform heel and toe walking. No motor weakness was noted and there was hyperreflexia

present in the lower extremities. No sensory loss was identified. Waddell's signs were absent. Follow up on 05/08/13 recommended facet injections at L3-4 to rule out facet joints as pain generators for the lumbar spine. The patient was seen on 06/05/13 with ongoing complaints of chronic low back pain. The patient did report a recent emergency room visit secondary to pain. The patient's physical examination demonstrated tenderness over the facet joints at L5 as well as tenderness of the lumbar spine over the L3-4 level. There was diminished sensation between the 1st and 2nd web space of the toes. appeal letter from 07/18/13, therapy was no longer available to the patient due to the development of neurogenic bladder. clarified that the facet joint injections were to address possible facet joint pain at L3-4.

The requested facet injections at L3-4 were denied by utilization review on 06/20/13 as there was a recommendation from guidelines that did not support the proposed procedures in patients with significant radiculopathy. There was also no evidence of a recent comprehensive non-operative treatment protocol.

The request was again denied by utilization review on 07/11/13 as there was no documentation regarding paravertebral tenderness on exam or indications that the patient had failed or was intolerant for physical therapy. There were also suggestions of a radicular component which was a contraindication per Official Disability Guidelines.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient has been followed for ongoing complaints of low back pain following a lumbar fusion at L4-5 and hardware removal at the same level. Prior imaging did show evidence of facet arthropathy at L3-4 as well as degenerative disc disease and spondylolisthesis. The patient's physical examination findings as well as did not show clear evidence of lumbar radiculopathy. There was no motor weakness, reflex changes, or sensory deficits in pertinent dermatomes that would support an L3-4 radiculopathy. The patient did have tenderness to palpation over the L3-4 facets consistent with the prior imaging findings. rationale for facet joint injections is to confirm whether the patient's L3-4 facets are a pain generator. The proposed facet joint injections would be appropriate at this point in time to either rule in or rule out the facet joints as a contributor to the patient's symptoms. Depending on the patient's response to the injections, will be able to further delineate care for this patient and consider different interventions. It is this reviewer's opinion that medical necessity for bilateral lumbar facet blocks L3-4 is established and consistent with guideline recommendations. As such, the prior denials are overturned at this time.

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)