

Clear Resolutions Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Oct/28/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: bilateral L4/5 facet joint injection

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., 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 the opinion of the reviewer that the request for bilateral L4/5 facet joint injection is not recommended as medically necessary.

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female whose date of injury is xx/xx/xx. She states that immediately she had pain in the back. The patient underwent lumbar epidural steroid injection L5-S1 on the left on 02/19/14. She states the pain in the back and legs was completely gone for the first 12 hours. MRI of the lumbar spine dated 03/21/14 revealed at L4-5 there is mild to moderate facet degenerative change. There is a small left foraminal disc protrusion causing mild narrowing of the left neural foramen. The central canal is patent. The patient underwent left L4-5 epidural steroid injection on 04/09/14 with some significant pain relief noted. The patient completed a course of physical therapy. She underwent left L4-5 transforaminal epidural steroid injection on 08/06/14. Physical therapy progress plan of care dated 08/21/14 notes lumbar rotation is pain free. Strength is 3/5 hip extensors, 4-/5 hamstrings, 3+/5 gluteus medius, and 5/5 quadriceps. Office visit note dated 08/28/14 indicates that transforaminal injection did help the leg pain quite a bit, but did not help much of the back pain. Current medications are Lyrica, Nabumetone, Zanaflex, Tylenol, Singulair, Allegra, Xopenex, Celebrex and Skelaxin. Office visit note dated 09/22/14 indicates that the patient complains of low back pain on the left side with bilateral calf pain. On physical examination there is tenderness to palpation lumbar spinous processes at L4-5, S1. Straight leg raising is negative bilaterally. There is decreased sensation to the left lateral calf and left great toe.

Initial request for bilateral L4-5 facet joint injection was non-certified on 09/11/14 noting that there is no exam to support doing anything for this patient at this time. The last exam was 7/22 per the office but the patient had an epidural steroid injection in the interim and radiculopathy needs to be ruled out and facet mediated pain with levels on exam needs to be ruled in. The denial was upheld on appeal dated 10/02/14 noting that facet joint injections are contraindicated with radicular symptoms. The patient complained of radiating pain down the bilateral lower extremities. The physical examination findings revealed decreased sensation to the left lateral calf and left great toe. The documentation does not show

evidence of the patient being treated with home exercise or physical therapy.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient continues to complain of radiating pain to the bilateral lower extremities. There is decreased sensation in the lower extremities noted on physical examination. The patient presents with a diagnosis of lumbar radiculopathy. The Official Disability Guidelines note that facet joint injections are limited to patients with low back pain that is non-radicular. The patient's compliance with an active home exercise program is not documented. As such, it is the opinion of the reviewer that the request for bilateral L4/5 facet joint injection is not recommended as medically necessary. The prior denials are upheld.

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)