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An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/05/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: bilateral lumbar facet injection at L3-4 L4-5

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Anesthesiology 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. It is the opinion of the reviewer that the request for bilateral lumbar facet injection at L3-4, L4-5 is not recommended as medically necessary.

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female whose date of injury is xx/xx/xx. On this date she ran into another employee. The patient is status post lumbar fusion at L3-4 in 2000, lumbar fusion in 2002 and fusion with cage in 2007. MRI of the lumbar spine dated 11/18/13 revealed laminectomy at L4 and L5 with bilateral pedicle screws, cage devices are in place at L4-5 and L5-S1. Progress note dated 05/30/14 indicates that the patient complains of low back pain that radiates down the bilateral hips into the bilateral lower limbs stopping at the feet. Medications are listed as Lorazepam, Reyataz, Norvir, Truvada, Trazodone, dicyclomine, ciprofloxacin, spironolactone, Lasix, Lyrica, Lidoderm patch, Voltaren topical, Oxycontin, Neurontin, Flexeril and duragesic patch. On physical examination there is tenderness left L1-2, L2-3, L3-4, right L2-3, L3-4, L4-5 and L5-S1. There is right hamstring 4/5 weakness and left quadriceps 4/5 weakness. Sensory exam is normal. Assessment notes lumbar radiculopathy, RSD, post-laminectomy syndrome, pelvic/hip pain, depression, edema and sacroiliitis.

Initial request for bilateral lumbar facet injection at L3-4, L4-5 was non-certified on 06/06/14 noting that according to guidelines, there should be no evidence of radicular pain, spinal stenosis or previous fusion. Clinical findings do not suggest facet joint pathology. This patient has radiating low back pain with decreased motor strength and altered reflexes on examination. She underwent lumbar fusion in 2003, 2005 and 2006. However, the levels involved were not specified. There was no indication that the patient has engaged in recent active rehabilitation to address low back pain prior to this injection request. Appeal letter from Dr. reiterated follow up note findings. The denial was upheld on appeal dated 06/23/14 noting that there is no clear objective documentation supporting symptomatic lumbar facets. The guidelines indicate therapeutic lumbar facet injections are under study as there is a lack of objective documentation supporting the efficacy of the procedure.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The submitted records indicate that the patient is status post lumbar fusion procedures in 2000, 2002 and 2007. It appears that fusion has been performed at L3-4 and L4-5. The Official Disability Guidelines note that facet injections should not be performed in patients who have had a previous fusion procedure at the planned injection level. Additionally, the patient presents with a diagnosis of lumbar radiculopathy. The Official Disability Guidelines note that facet injections are limited to patients with low back pain that is non-radicular. There is no indication that the patient has undergone any recent active treatment. As such, it is the opinion of the reviewer that the request for bilateral lumbar facet injection at L3-4, L4-5 is not recommended as medically necessary.

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)