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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jun/23/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Bilateral facet injections @ L5-S1 with IV sedation

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O., 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 this reviewer that the request for bilateral facet injections @ L5-S1 with IV sedation is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who reported a long history of low back pain. The clinical note dated 08/21/09 indicates the patient having previously undergone a lumbar fusion with implantation of a cage in 1998. The patient did report returning to work in shipping and receiving. The patient did report an increasing level of back pain with left sided paresthesia at the posterior thigh. The patient rated his ongoing back pain as 7-8/10. The operative report dated 02/05/10 indicates the patient undergoing a bilateral L4-5 facet injection. The clinical note dated 01/28/10 indicates the fusion at the L5-S1 level. The patient continued with ongoing symptoms. The patient stated that he was having difficulty standing and walking for prolonged periods of time. The patient did report radiating pain from the low back into both lower extremities, left greater than right. The previous facet injections in 2010 did provide minor relief. The CT scan of the lumbar spine dated 03/10/14 revealed degenerative changes at L4-5. There is evidence of a previous surgery in the lower regions of the lumbar spine. The MRI of the lumbar spine dated 03/25/14 revealed a metallic susceptibility artifact at L5-S1 suggestive of an intervertebral disc spacer. A disc bulge was identified at L4-5 with no significant thecal sac narrowing. Mild right neuroforaminal narrowing was identified at L5-S1 as well. The clinical note dated 03/28/14 indicates the patient demonstrating symmetric reflexes at the knees. The patient was recommended for a facet injection at that time.

The clinical note dated 04/16/14 indicates the patient continuing with severe levels of low back pain as well as left sided buttocks pain. Radiating pain was identified at the left lower extremity. Weakness was also identified in the lower extremities.

The utilization review dated 04/04/14 resulted in a denial for a facet injection at L5-S1 as the

patient was identified as having undergone a previous fusion at L5-S1.

The utilization review dated 04/14/14 resulted in a denial as the patient had not had any recent physical therapy.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The documentation indicates the patient complaining of low back pain with radiating pain to the left buttocks and left lower extremity. The documentation does indicate the patient having undergone an L5-S1 fusion. A previous fusion at the intended level of the proposed facet injection was a contraindication to the success of the outcome of the proposed injection. Additionally, no information was submitted regarding the patient's recent completion of any conservative therapies. Furthermore, the patient has been identified as having previously undergone a facet injection. However, no information was submitted regarding the patient's objective functional improvement following the injection. Given these factors, it does not appear that the proposed facet injection would be appropriate for this patient at this time. As such, it is the opinion of this reviewer that the request for bilateral facet injections @ L5-S1 with IV sedation 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)