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An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jul/15/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: paravertebral facet joint injection left L4-5, L5-S1 with imaging guidance

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Physical Medicine and Rehabilitation 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 paravertebral facet joint injection left L4-5, L5-S1 with imaging guidance is not recommended as medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a xx year whose date of injury is xx/xx/xx. The mechanism of injury is not described. The patient underwent right L3-5 radiofrequency ablation on 04/06/15. Office visit note dated 04/27/15 indicates that RFTC has been recommended. The patient is much improved after treatment. The patient complains of low back pain bilaterally. The patient is not currently taking any medications. On physical examination there is tenderness off midline only on the left in the paraspinal muscles. Active flexion is full and asymptomatic to 75 degrees. Extension is full to 25 degrees with low back pain on the left. Sensation is intact in the lower extremities. Deep tendon reflexes are 2+ throughout the lower extremities. Straight leg raising is asymptomatic bilaterally.

Initial request for paravertebral facet joint injection left L4-5, L5-S1 with imaging guidance was non-certified on 05/06/15 noting that the patient had a right L3, L4 and L5 nerve level radiofrequency ablation on 04/06/15. The claimant is much improved after the treatment. The claimant's response to the previous facet injection is not outlined. Moreover, there is no clear indication for another diagnostic block as the claimant was already provided this procedure in the past at the same lumbar levels. The denial was upheld on appeal dated 06/17/15.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient sustained injuries on xx/xx/xx due to an unknown mechanism of injury. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. The patient has reportedly undergone previous facet injections and radiofrequency ablation. The patient's objective functional response to these procedures is unknown. The Official Disability Guidelines would not support a confirmatory set of injections. Given the lack of supporting

documentation, medical necessity is not established in accordance with the Official Disability Guidelines. As such, it is the opinion of the reviewer that the request for paravertebral facet joint injection left L4-5, L5-S1 with imaging guidance is not recommended as medically necessary and 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)