

US Decisions Inc.

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DATE NOTICE SENT TO ALL PARTIES: Nov/10/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Bilateral L4/5, L5/S1 Facet injection

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: DO, 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 the request of Bilateral L4/5, L5/S1 Facet injection has not been established.

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who was injured on XX/XX/XX while unloading freight. The patient developed complaints of low back pain radiating to the left hip region. The patient was initially referred to physical therapy and given anti-inflammatories. MRI studies of the lumbar spine from 05/05/14 noted disc bulging at L4-5 and L5-S1 with some facet hypertrophy that did not contribute to significant central or foraminal narrowing. The patient did have 2 prior caudal epidural steroid injections completed on 05/05/15 and 06/30/15. There was a clinical report on 08/14/15 noting that the patient did have improvement following the epidural steroid injections. The patient continued to have complaints of low back pain worse than leg pain. The physical examination noted intact strength with loss of lumbar range of motion. The 10/01/15 report noted ongoing low back complaints. No changes in physical examination were noted. There was pain with facet loading evident on physical examination. The recommendation at this evaluation was for lumbar facet injections at L4-5 and L5-S1 to help differentiate pain generators by level. It was not clear whether the patient was being considered for future rhizotomy procedures. The proposed bilateral L4-5 and L5-S1 facet injections were denied by utilization review on 10/12/15 as there was no evidence of a recent comprehensive non operative treatment protocol prior to the recommendation for facet injections. The request was again denied on 10/16/15 as it was unclear what the patient's source of pain was.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: In review of the clinical records submitted, the patient was being followed for complaints of low back pain more so than leg pain. The clinical documentation did not identify any clear evidence of neurological deficit consistent with radiculopathy although the patient did have multiple caudal epidural steroid injections completed. The clinical evaluation in October 2015 did note pain with lumbar facet loading. The patient was recommended for facet injections in order to differentiate pain generators. The clinical records did not indicate whether medial branch blocks were being considered for this patient. Therapeutic facet injections are not recommended by guidelines.

There was also no discussion regarding considering possible radiofrequency ablation procedures depending on the results from facet injections. Given the unclear nature of the requested injections, it is this reviewer's opinion that medical necessity for the request of Bilateral L4/5, L5/S1 Facet injection has not been established. Therefore, the prior denials remain 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)