

Clear Resolutions Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

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

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: left L3-S1 lumbar facet injection

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O., 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 this reviewer's opinion that medical necessity for the request for left L3-S1 lumbar facet injection

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who sustained an injury on xx/xx/xx. No specific mechanism of injury was noted. The patient was seen on 10/21/14 for complaints of pain in the lumbar region despite multiple medications to include Neurontin, Ultram, Cymbalta, Hydrocodone, and Tylenol. The patient's physical examination noted tenderness over the lumbosacral junction over the left sided lumbar paraspinal musculature. The patient is noted to have a diagnosis of lower extremity radiculopathy with a new onset of facet joint syndrome. Recommendations were for therapeutic facet joint injections to the left from L3 through S1.

The requested facet joint injections from L3 through S1 were denied by utilization review on 12/12/14 and on 01/13/15 due to the number of injections requested.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient has been followed for chronic complaints of low back pain. It does appear that the patient has had prior surgery for the lumbar spine; however, its type and extent have not been documented. Per current evidence based guidelines, lumbar facet injections as a therapeutic procedure are not well-supported in the current clinical literature. For facet syndrome, the recommendation is for diagnostic medial branch blocks to determine pain response followed by consideration for lumbar facet rhizotomy procedures. The patient's physical examination noted tenderness over the lumbar paraspinal musculature to the left; however, there were no objective findings for facetogenic pain to include pain with lumbar facet loading. It is unclear whether the patient has had any recent physical therapy and facet injection procedures are not recommended for patients who have had prior lumbar fusion procedures. As it is unclear to what extent surgery has been completed for this patient as well as the lack of documentation regarding objective evidence for facetogenic pain and as guidelines do not support therapeutic injections over diagnostic blocks, it is this reviewer's opinion that medical necessity for the request for left L3-S1 lumbar facet injection is

not established 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)