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Notice of Independent Review Decision

DATE OF REVIEW: December 30, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Bilateral L4-5 facet joint injection with intravenous (IV) sedation (64493, 77003 and 99144).

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

M.D., Board Certified in 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)

The requested bilateral L4-5 facet joint injection with intravenous (IV) sedation (64493, 77003 and 99144) is not medically necessary.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported a work-related injury on xx/xx/xx. According to the documentation submitted for review, the patient underwent an artificial disc replacement at L5-S1 in October 2005. On 11/7/14 the patient underwent magnetic resonance imaging (MRI) of the lumbar spine which revealed postoperative changes at the L5-S1 with associated metallic susceptibility artifact; facet hypertrophy at the L4-5 with minimal bilateral foraminal narrowing; and minimal degenerative disc disease and moderate facet arthritis. The patient was evaluated on 11/17/14 for complaints of low back pain. The provider noted that the patient's pain radiated to the right posterior knee. The provider further noted that the patient was sitting comfortably and did not have difficulty acquiring a full, upright position when getting out of the chair. Upon

physical examination the provider reported tenderness to the bilateral paravertebral muscles. Range of motion was noted as painful, unrestricted with extension and lateral bending bilaterally. Lower extremity strength was noted as symmetrically present in all lower extremity muscle groups. Lower extremity reflexes were symmetrically present and normal. Light touch was normal for all lumbar dermatomes. At that time the provider recommended bilateral facet injections at the L4-5 level.

The URA indicated that the patient did not meet Official Disability Guidelines (ODG) criteria for the requested services. Per the denial letter dated 12/8/14, the URA indicates the patient's main complaint is back pain that radiates to his posterior knee and there is no indication that the patient has plans to attend any physical therapy before or after the injection.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

The Official Disability Guidelines (ODG) recommend diagnostic blocks for facet mediated pain for patients when there is documentation of failure of conservative treatment to include home exercise, physical therapy, and non-steroidal anti-inflammatory drugs (NSAIDs). The documentation submitted for review did not demonstrate that the patient had participated in a physical therapy program. Guidelines additionally state the use of intravenous (IV) sedation may be grounds to negate the result of a diagnostic block, and should only be given in cases of extreme anxiety. There is no documentation demonstrating that the patient has severe anxiety. Further, the documentation submitted for review does not address whether the requested facet joint injections were for diagnostic or therapeutic purposes. There is no indication the proposed facet joint injections would preclude a facet neurotomy. The guidelines recommended the use of facet injections prior to facet neurotomies if a neurotomy is chosen as an option for treatment. The documentation does not mention that a neurotomy had been chosen as a treatment option for this patient. For the reasons provided, the medical necessity for the requested services has not been established. In accordance with the above, I have determined that the requested bilateral L4-5 facet joint injection with IV sedation is not medically necessary for treatment of the patient's medical condition.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN 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 JUDGMENT, 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)