

May 11, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Medical Necessity of Bilateral Lumbar Facet Injections @ L5/S1 with IV sedation (CPT codes 64493, 77003, J2250, J3301, 01992)

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

The physician performing this review is Board Certified, American Board of Physical Medicine & Rehabilitation. The physician is certified in pain management. The physician has a private practice of Physical Medicine & Rehabilitation, Electro Diagnostic Medicine & Pain Management in Texas. The physician is a member of the Texas Medical Association and the Houston Physical Medicine and Rehabilitation Society. The physician is licensed in Texas and Michigan and has been in practice for over 25 years.

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 of the health care services in dispute.

Upon independent review the physician finds that the previous adverse determination should be ~ Upheld

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a man reportedly was injured on xx/xx/xx. He has noradicualr back pain that increases with activity. The pain was recreated with spinal extension and rotation and at the facet region from L4/5 to L5/S1.

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

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Prior reviewers discussed and questioned the need for IV sedation, but did not question the need for the facet injection itself. So the justification for the procedure itself is not the question. wrote on 2/12/15 “The Patient communicates a willingness for anesthesia during the procedure. The patient expresses a mental and/or psychological impediment to not having a degree of relaxation medication whilst this procedure is being performed.” The question is if this is the severe anxiety as listed in criteria 8. This was not clear and as such, the procedure cannot be approved if sedation is necessary. The ODG is the approved manual by the Division of Workers Compensation in Texas.

Criteria for the use of diagnostic blocks for facet “mediated” pain:

Clinical presentation should be consistent with [facet joint pain, signs & symptoms](#).

1. One set of diagnostic medial branch blocks is required with a response of $\geq 70\%$. The pain response should last at least 2 hours for Lidocaine.
2. Limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally.
3. There is documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks.
4. No more than 2 facet joint levels are injected in one session (see above for medial branch block levels).
5. Recommended volume of no more than 0.5 cc of injectate is given to each joint.
6. No pain medication from home should be taken for at least 4 hours prior to the diagnostic block and for 4 to 6 hours afterward.
7. Opioids should not be given as a “sedative” during the procedure.
8. The use of IV sedation (including other agents such as midazolam) may be grounds to negate the results of a diagnostic block, and should only be given in cases of extreme anxiety.
9. The patient should document pain relief with an instrument such as a VAS scale, emphasizing the importance of recording the maximum pain relief and maximum duration of pain. The patient should also keep medication use and activity logs to support subjective reports of better pain control.
10. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated. ([Resnick, 2005](#))
11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. [Exclusion Criteria that would require UR physician review: Previous fusion at the targeted level. ([Franklin, 2008](#))]

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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 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)