

C-IRO Inc.

An Independent Review Organization

1108 Lavaca, Suite 110-485

Austin, TX 78701

Phone: (512) 772-4390

Fax: (512) 519-7098

Email: resolutions.manager@ciro-site.com

DATE AMENDED NOTICE SENT TO ALL PARTIES: Jun/14/2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: left L4-L5 and L5-S1 lumbar facet steroid injection under fluoroscopy

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: DO, Board Certified Physical Medicine and Rehabilitation

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 this reviewer the request for left L4-L5 and L5-S1 lumbar facet steroid injection under fluoroscopy is not medically necessary.

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male with complaints of back pain. On XX/XX/XX, an MRI of the lumbar spine revealed at L4-5, there was a large central posterior disc herniation, of the extrusion type, compressing into the thecal sac. At L3-4, there was a posterior disc herniation, more prominent in the central aspect, with post-surgical left hemilaminectomy changes seen, with slight epidural fibrotic scarring as well as a posterior disc herniation which was central and right in location, measuring approximately 4.8mm in the AP diameter. On XX/XX/XX, the patient was taken to surgery for a left lumbar facet steroid injection at the L4-5 and L5-S1 levels using sedation. On XX/XX/XX, the patient returned to clinic. The patient was noting little back pain bilaterally, and was taking Celebrex for the low back pain. He reported still having some back pain, but not as much before and noted relief from the previous injection. He was status post left lumbar facet steroid injections on XX/XX/XX.

On exam, motor strength was good in the bilateral lower extremities, and the patient was tender over the lumbar paraspinal muscles at L5-S1 bilaterally, with slight pain on rotation and extension left greater than right. On XX/XX/XX, the patient returned to clinic. He again noted some relief from the previous lumbar facet injection performed on XX/XX/XX. On exam, motor strength was 5/5, deep tendon reflexes were trace in both quadriceps, and absent in both plantar reflexes, and sensation was intact to lower extremities. He was to be scheduled for a left lumbar facet steroid injection at left L4-5 left L5-S1.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: On XX/XX/XX, a utilization review report stated the request for a left L4-5 and L5-S1 lumbar facet steroid injection under fluoroscopy was non-certified. It was noted that clarification was needed with regards to the percent and duration of pain relief that the patient received post-injection as guidelines state that if injection is successful with pain relief of at least 50% for a duration of at least six weeks, the recommendation is to proceed to a medial branch diagnostic block with a subsequent neurotomy if the medial branch block is positive. Official Disability Guidelines low back chapter was utilized as a reference source.

On XX/XX/XX, a utilization review report stated the request for left L4-5 and L5-S1 lumbar facet steroid injection under fluoroscopy, on appeal, was non-certified. It was noted that in the appeal letter, the provider stated this injection had provided over 50% pain relief. The guidelines state only one medial branch block is reasonable prior to radiofrequency ablation procedure, and the guidelines do not support therapeutic facet joint injections. The provider had not documented whether the requested procedure was going to be a repeat medial branch block, or a repeat therapeutic facet joint injection and this should be clarified. The request was non-certified and Official Disability Guidelines low back chapter was cited as a reference source.

The patient was taken to surgery on XX/XX/XX, and received a left lumbar facet steroid injection at L4-5 and L5-S1 for a diagnosis of traumatic lumbar facet arthropathy. The XX/XX/XX progress note indicated the patient had received relief from the injection but this was not objectively documented on a VAS or other similar scale. In the XX/XX/XX appeal letter, the provider stated that the request was not for medial branch block injection, but for a left lumbar facet steroid injection at L4-5 and L5-S1. It was noted the patient had pain rated at 5-6/10 on XX/XX/XX prior to the injection, and the pain was reduced on XX/XX/XX (possibly an error) at 2/10. This lasted for three months.

The provider has clarified that the request is for left lumbar facet steroid injection at L4-5 and L5-S1. This is the same type of injection as received on XX/XX/XX. The provider also resubmitted the letter with this clarification, which did not provide significant, substantial, new information.

Official Disability Guidelines states that multiple facet injections are not recommended. The guidelines say that where more than one therapeutic intraarticular block is suggested, and if successful with pain relief of at least 50% for six weeks, the recommendation is proceed to a medial branch diagnostic block and subsequent neurotomy with the medial branch block is positive.

Is the opinion of this reviewer the request for left L4-5 and L5-S1 lumbar facet steroid injection under fluoroscopy between XX/XX/XX-XX/XX/XX is not 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)