

# C-IRO Inc.

An Independent Review Organization

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**DATE NOTICE SENT TO ALL PARTIES:** Mar/11/2016

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** Bilateral L4/S1 Facet Joint Injection

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** MD, 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 the opinion of the reviewer that the request for Bilateral L4/S1 Facet Joint Injection is not recommended as medically necessary

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male whose date of injury is XX/XX/XX. The patient reported low back pain after lifting a heavy object. MRI of the lumbar spine dated XX/XX/XX revealed at L4-5 there is a 4.5 mm central disc protrusion which effaces the thecal sac. There are early facet hypertrophic changes, minor bilateral neural foraminal narrowing and mild bilateral subarticular zone narrowing. At L5-S1 there was a 5.8 mm right paracentral disc protrusion that minimally contacts without displacing the right S1 nerve root. There is an abundance of anterior epidural fat at this level. There is no central canal stenosis. There are early facet hypertrophic changes, minor to mild bilateral neural foraminal narrowing. Note dated XX/XX/XX indicates that the patient has completed 10 physical therapy visits. The patient reports no change in symptoms. On physical examination active range of motion is reduced. Straight leg raising is positive bilaterally. Follow up note dated XX/XX/XX indicates that the patient is still having complaints of pain in his low back. He has just completed physical therapy. He states physical therapy did not help him. He states he had an epidural steroid injection in the past that did not help him. The patient was recommended for L4-5 and L5-S1 facet injections to rule out facet mediated pain.

Initial request for bilateral L4 S1 facet joint injection was non-certified on XX/XX/XX noting that these injections have not been proven in medical literature to be an effective treatment. The denial was upheld on appeal dated XX/XX/XX noting that the medical records did not document physical examination findings positive for specific facet joint mediated pain for which ODG would recommend a diagnostic facet joint injection.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient sustained a lifting injury to the low back on XX/XX/XX and has completed a course of physical therapy. The patient has subsequently been recommended for facet joint injections to rule out facet mediated pain. However, the Official Disability Guidelines note that the patient's clinical presentation should be consistent with facet joint pain, signs and symptoms. The patient's physical examination

fails to establish the presence of facet-mediated pain.

There is no documentation of increased pain on extension and/or rotation and no documentation of tenderness to palpation over the facet joints. As such, it is the opinion of the reviewer that the request for Bilateral L4/S1 Facet Joint Injection is not recommended as 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)