P-IRO Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:
Dec/07/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Lift L5, Left S1 lumbar facet

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

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] 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 <u>each</u> health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
ODG - Official Disability Guidelines & Treatment Guidelines
Request for IRO 11/19/12
Receipt of request for IRO 11/20/12
Utilization review determination 10/10/12
Utilization review determination 10/31/12
Utilization review report 10/09/12
Utilization review report 10/31/12
Clinical notes 09/28/12 and 10/25/12
MRI lumbar spine 09/26/10

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a male who was reported to have sustained work related injuries to his low back on xx/xx/xx. It was reported that on the date of injury he was pulling out of the mud. While doing so, he lifted and twisted with his body and felt a sharp pain in the low back area. He subsequently was seen by a company doctor and provided oral medications and referred for physical therapy and he was later referred for MRI of the lumbar spine on 09/27/10 at which time he was noted to have no pathology from L1-2 through L3 through L4-5 and at L5-S1 there was a broad based central disc herniation of 4-5mm demonstrated and the neural foramina were reported to be patent. The claimant was later seen who recommended surgical intervention, but it was not approved under utilization review. The claimant subsequently came under the care of who recommended that a fusion surgery be performed. This was not supported under utilization review.

On 09/28/12, the claimant was seen and the claimant was reported to have 7/10 pain and his complaints were primarily axial mechanical back pain on the left side of the body. On physical examination, he had tenderness over the left L5-S1 region, positive Kemp sign, decreased range of motion in extension, intact motor strength and sensation and reflexes. Radiographs were reported to show no bony abnormalities or fractures or subluxations and the claimant was opined to have facet mediated pain on the left at L5 and S1 and he subsequently was recommended to undergo medial branch blocks on the left at L5-S1.

The claimant was seen in follow up on 10/25/11 and noted the denial letter for the requested procedure and he noted that the initial reviewer reported that the claimant had been recommended to undergo fusion. In that case, a medial branch block would not be supported when the patient has had a fusion performed to his lumbar spine. subsequently noted that the requested procedure was to treat the axial back pain.

On 10/09/12, the claimant on 10/09/12 performed the initial review. She noted that the claimant had evidence of a protrusion at L5-S1. She noted on examination he had back pain with no neurological findings and tenderness over the left L5-S1 facet pain with extension and a positive Kemp sign and that it had been reported that a fusion had been suggested. She noted that although this was not supported, any indication that a fusion may be needed was a contraindication for facet procedures and that only one CPT code was submitted for this. She noted that the request is incorrectly submitted if it was intended to perform a two level medial branch block.

The appeal review was performed on 10/31/12 who non-certified the appeal request noting that straight leg raise was noted to elicit pain and that a fusion had been contemplated for the patient and that a concomitant plan for exercise or therapy had not been identified.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The request for left L5 and S1 facet injections is not supported by the submitted clinical information and the prior utilization review determinations are upheld. The submitted clinical records indicate that the claimant has complaints of low back pain with some which is primarily axial in nature. The record includes an MRI of the lumbar spine as well as plain radiographs as interpreted which showed no objective evidence of pathology at the L5-S1 and no objective evidence of facet pathology at the L5-S1 levels. The claimant is reported to have lumbar tenderness with and is neurologically intact. Specifically, the physical examination does not isolate the L5-S1 facets and there is some suggestion of a subtle radiculopathy on examination and it would further be noted that on multiple indications the claimant has been recommended to undergo surgical intervention and this in itself would be exclusionary to the performance of lumbar facet injections. Therefore, based upon the submitted clinical information, the claimant would not meet criteria per Official Disability Guidelines and the prior determinations have been 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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)