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Notice of Independent Review Decision

DATE OF REVIEW: February 27, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Bilateral L4-5, L5-S1 lumbar facet block injections using fluoroscopy and total intravenous sedation.

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 with Subspecialty Certification in 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)

I have determined that the requested bilateral L4-5, L5-S1 lumbar facet block injections using fluoroscopy and total intravenous sedation are not medically necessary for the treatment of the patient's medical condition.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained injuries on xx/xx/xx. While riding on a bicycle, he was struck by a car, causing him to be ejected into the air. He landed directly on his back with his left arm underneath him, and he hit his head on the ground. The patient presented for a follow-up appointment on 9/04/14 with complaints of pain in the neck, upper/mid back and low back, with radiation of pain into the left lower extremity. He reported that the pain was constant and rated as 4/10 to 7/10. The patient's medications included hydrocodone and over-the-counter

medications. Upon examination, the patient had intact sensation to light touch in the bilateral upper and lower extremities, intact strength in the bilateral upper and lower extremities of 5/5, and a negative straight leg raise. There was decreased range of motion noted. The patient's diagnoses included lumbar pain, lumbar sprain/strain, and lumbar radiculopathy. A request has been submitted for coverage for bilateral L4-5, L5-S1 lumbar facet block injections using fluoroscopy and total intravenous sedation.
The URA indicates that the patient does not meet Official Disability Guidelines (ODG) criteria for the requested services. Specifically, the initial denial stated that according to ODG criteria, facet joint diagnostic blocks are limited to patients with low back pain that is non-radicular and at no more than two levels bilaterally. Per the URA, the facet blocks are not warranted as the patient has radiculopathy on both examination and electromyography. On appeal, the URA noted that the treatment for facet syndrome is not authorized in conjunction with concurrent radiculopathy.

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

According to Official Disability Guidelines (ODG), facet joint diagnostic block is recommended with the anticipation that if successful, treatment may proceed to facet neurotomy at the diagnosed levels. This is limited to patients with low back pain that is non-radicular and no more than two levels bilaterally. There should be documentation of failure to respond to conservative treatment, including physical therapy and medications, preceding the procedure for at least four to six weeks. Per ODG, the use of intravenous sedation may negate the results of a diagnostic block and should only be given in cases of extreme anxiety. In this case, there is lack of evidence of the patient's failure to respond to initially recommended conservative treatment. Additionally, the patient has a diagnosis of lumbar radiculopathy, which is an exclusionary criterion of the requested treatment. As such, the requested bilateral L4-5, L5-S1 lumbar facet block injections using fluoroscopy and total intravenous sedation are not medically indicated in this patient's case.

Therefore, I have determined the requested bilateral L4-5, L5-S1 lumbar facet block injections using fluoroscopy and total intravenous sedation are 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)**