Date notice sent to all parties: 4/18/2019

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
The item in dispute is the prospective medical necessity of intra-articular facet injection at XX-XX and XX-XX with fluoroscopy performed under anesthesia, XX / XX XX.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The reviewer is a Medical Doctor who is board certified in Anesthesiology.

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of intra-articular facet injection at XX-XX and XX-XX with fluoroscopy performed under anesthesia, XX / XX XX.

PATIENT CLINICAL HISTORY [SUMMARY]:
This XX-year-old XX was injured on XX. The mechanism of injury occurred when XX was XX a XX off the XX. The diagnoses were chronic XX pain and secondary XX pain syndrome. Physical examination on XX stated that XX continued to have severe XX mid XX and XX pain associated with XX XX syndrome having failed surgical rehabilitative medical treatment options. The pain was aggravated with XX bending and extension and radiated to the lateral side with tenderness. It was noted that intravenous sedation in the prone position is required due to multiple XX fixed under fluoroscopic control. XX had a desire to get off of medications. Medications at the time included XX, XX and XX. XX had exhausted all previous treatment and paradigm models for this condition. It was noted that

the guidelines supported intra-articular XX injections followed by medial branch blockade in radiofrequency XX. An initial pain evaluation dated XX noted that XX had persistent XX XX pain that responded favorably to a single intra-articular facet injection over a XX ago. The pain has worsened. XX admitted to XX and XX XX. XX tried XX therapy, non-steroidal anti-inflammatory drugs, and muscle relaxants with no relief. XX XX XX pain was worse with extension, XX bending, and most routine daily activities requiring any type of XX. Objective findings included XX para XX increased tone and spasm extending from the XX/XX to XX/XX interspace. XX had XX-XX as well as XX XX to XX over the XX facet and XX facet joints which are aggravated by XX bending. It only radiated to XX lateral XX and XX area did not go below the level of any. XX XX MRI report dated XX showed XX nodes and end plate irregularity involving the inferior half of the XX XX and XXmm XX XX throughout the inferior half of the XX XX. There was no evidence of a large disc herniation, XX XX XX, or neural XX encroachment at any XX level. A XX XX MRI report dated XX showed a broad XX mm XX XX/XX with the XX mm central component and potential XX nerve root XX with mild XX XX XX at XX-XX.

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

Per evidence-based guidelines, and the records submitted, this request is non-certified. Per ODG, excessive sedation should be avoided when performing facet injections. The use of sedation during facet injection remains controversial and is indicated for XX. There is no documentation of XX or other clinical or XX XX that would warrant sedation for this routine procedure. As such, the request for intra-articular facet injection at XX/XX and XX/XX with fluoroscopy performed under anesthesia is not medical necessary.

Official Disability Guidelines- Treatment for Worker's Compensation, Online Edition
Chapter: XX XX- XX and XX

XX

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 XX XX 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)**