

# MEDICAL REVIEW OF TEXAS

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**DATE OF REVIEW:**            JUNE 11, 2007

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Facet joint blocks at L4-5 and L5-S1

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION**

Board Certified  
TWCC Designated Doctor

**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 or not medical necessity exists for each of the health care services in dispute.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Non-certification of pre-authorization request (5/4/07)  
Non-certification of pre-authorization request (4/26/07)  
Request for pre-authorization and chart notes from requestor  
(4/13/07, 3/12/07, 10/17/06, 9/11/06)  
MRI report (7/21/06)  
Designated Doctor report (3/13/07)  
Procedure note epidural steroid injection (2/26/07)

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The earliest note presented is a xx/xx/xx lumbar MRI noting a posterior annular tear at L5-S1 and the upper SI and axial tomographs are symmetric and normal in appearance. The facet joints were noted to be "widely patent and unremarkable". The claimant had been seeing another provider and the initial evaluation by the requestor occurred

on xx/xx/xx. The reported mechanism of injury was noted as falling into a seated position from an office chair. The pain was localized and there was a reported worsening of bladder issues. Multiple medications had been prescribed. The physical examination noted the claimant to be obese (BMI > 31 5'3" 220 lbs). The initial diagnosis was spondylosis and annular tear. This was treated with an ESI. The initial request for the ESI was not certified and the requesting provider apparently took umbrage to this determination.

There is a four month gap in the notes; the next note being xx/xx/xx and this was the procedure note for the ESI. In xxxx the claimant had progressed to a RTC on a PRN basis only status.

A Designated Doctor evaluation was completed noting that the diagnosis was lumbar disc disorder and that maximum medical improvement had not been reached. The physical examination noted diffuse pain in the piriformis and bilateral facet regions only. Pain with facet loading was reported as well. Facet injections were suggested. The requesting provider noted this and sought out the pre-authorizations. (This treatment/procedure was not a consideration the day prior to the Designated Doctor evaluation.)

The request was not certified by an occupational specialist based on an inability to speak with the requesting provider. The first level appeal was non-certified by an orthopedic surgeon.

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

This is an lady with a diffuse history of low back pain. The original treatment was rendered by another health care provider and those notes were not supplied for review. The requesting provider noted the low back pain and obtained an MRI. This imaging study noted that the facet joints were widely patent and there was no pathology presented. the requesting party pursued the noted disc pathology with an ESI which was apparently successful. The day prior to the Designated Doctor evaluation, there was no clinical indication or consideration that the pain generator was the facet joints. Axial loading and pain with lumbar extension in the region of the facet joints led the Designated Doctor to suggest that facet injections were indicated. It appears that the co-morbidities and other maladies were not included into the problem list or differential diagnosis.

Given the reported mechanism of injury, the lack of findings noted on physical examination by the requesting provider, the lack of objective pathology noted on plain films and MRI imaging studies and the multiple co-morbidities, it is not clear that there is a facet lesion that

warrants intervention. This has all the appearance of a “shot in the dark”. Beyond that, the ODG notes that facet injections are under study. As noted in the April 13 progress notes from the requesting provider the purpose would be to determine the level. However, the pathology is an annular tear and the response to the ESI supports that diagnosis.

Another consideration is that the requesting provider is addressing an ordinary disease of life in this lady and this is not addressing the compensable injury alone.

A review of the literature noted several key points, beyond those noted in the ODG. In their large 1988 study, Jackson et al could not identify clinically specific facet syndromes or could not predict with any degree of accuracy which patients were more likely to respond to facet diagnostic blocks. They concluded that facet syndrome is not a reliable clinical diagnosis. Studies addressing the pattern of referred pain have been unable to distinguish pain from different levels. However, a generally held belief is that facet joint pain is more prevalent among the older population, is more lateralized, and is more likely a diagnosis when radiographic findings show severe facet arthritis. This would endorse that what is being addressed is not related to the compensable injury. At this point one has to consider the causes of facet joint pain. As noted by Shin and Shipman (writing for e-Medicine 10/6/06) these causes include “Osteoarthritis is another cause of lumbar facet joint pain. However, not all cases of facet arthritis are painful; radiographic changes of osteoarthritis are equally common in patients with and without LBP. Some studies report that severely degenerated joints are more likely to cause symptoms. Dory attributed LBP from facet syndrome to distention and inflammation of the synovial capsule, with resultant stimulation of the nociceptive nerve endings. Expanded synovial recesses also may compress nerve roots in the spinal canal and neural foramina, which may explain the presence of radicular pain in patients with facet syndrome. Lippitt attributed pain in facet syndrome to a combination of synovitis, segmental instability, and degenerative arthritis. Other theories include meniscoid entrapment, synovial impingement, joint subluxation, chondromalacia facette, capsular and synovial inflammation, mechanical injury to the joint capsule, and restriction to normal articular motion from soft or articular causes.”

In short this facet injection is not indicated based on the physical examination of the requesting provider, not indicated based on the specifics of the MRI noting that the tomographs were wholly normal, and the fact that the age and body habitus are probably more causative than the reported mechanism of injury.

**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 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
  - \* Shin and Shipman; e-Medicine 10/6/06
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)