

SENT VIA EMAIL OR FAX ON
Dec/31/2008

Independent Resolutions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Dec/29/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L5/S1 facet injection

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

Board Certified in Physical Medicine and Rehabilitation
Subspecialty Board Certified in Pain Management
Subspecialty Board Certified in Electrodiagnostic Medicine
Residency Training PMR and ORTHOPAEDIC 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines
Denial Letters 9/25/08 and 10/20/08
Records from Dr. 8/15/08 thru 11/24/08
MRI's 5/27/08 and 4/24/07
Radiology Reports 8/19/08, 5/21/07 and 7/19/07
Records from Medical Centers 2/11/08 thru 8/4/08
Record from Dr. 6/18/08
Records from Dr. 7/7/07 thru 12/18/07
OP Report 9/24/07

PATIENT CLINICAL HISTORY SUMMARY

This is a xx year old man who was injured as a result of motor vehicle accident in xx/xx/xx. He had an injury to his right wrist and lower back. The question is directed to the low back region. He had seen several practitioners with some variation in physical findings. He was found to have limited motion in the lumbar spine, especially along the L3/4 region. Others reported SI pain or pain in the lumbar region on extension. He had local tenderness along the mid to lower lumbar spine. He had reduced sensation reportedly along the left and right L3 dermatomes. He was found to have some slight reduction in the right ankle jerk and gastrocnemius strength. Other examiners described pain to the buttock, more to the right than the left and right quadriceps weakness.

An MRI was done on 5/27/08. It showed degenerative changes with a disc degeneration and broad based disc herniation at L5/S1. The left and right S1 roots are probably compressed. There was mild facet hypertrophy at L3/4 and L4/5. There was no comment about the L5/S1 region.

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

The Reviewer is not discussing the wrist.

The request for facet injections first requires confirmation of the facets as the pain generator. There is no reason to exclude a radiculopathy as another causal relationship as there are reported reduction of the right ankle jerk and reduced right gastrocnemius strength. This is compatible with the MRI description of the S1 root compromise. The pain symptoms are referred to areas described in the ODG.

Facet joint pain, signs & symptom

Recommend diagnostic criteria below. Diagnostic blocks are required as there are no findings on history, physical or imaging studies that consistently aid in making this diagnosis. Controlled comparative blocks have been suggested due to the high false-positive rates (17% to 47% in the lumbar spine), but the use of this technique has not been shown to be cost-effective or to prevent a false-positive response to a facet neurotomy. (Bogduk, 2005) (Cohen 2007) (Bogduk, 2000) (Cohen2, 2007) (Manchukonda 2007) (Dreyfuss 2000) (Manchikanti 2003) The most commonly involved lumbar joints are L4-5 and L5-S1. (Dreyfus, 2003) In the lumbar region, the majority of patients have involvement in no more than two levels. (Manchikanti, 2004)

Mechanism of injury: The cause of this condition is largely unknown, but suggested etiologies have included microtrauma, degenerative changes, and inflammation of the synovial capsule. The overwhelming majority of cases are thought to be the result of repetitive strain and/or low-grade trauma accumulated over the course of a lifetime. Less frequently, acute trauma is thought to be the mechanism, resulting in tearing of the joint capsule or stretching beyond physiologic limits. Osteoarthritis of the facet joints is commonly found in association with degenerative joint disease. (Cohen 2007)

Symptoms: There is no reliable pain referral pattern, but it is suggested that pain from upper facet joints tends to extend to the flank, hip and upper lateral thighs, while the lower joint mediated pain tends to penetrate deeper into the thigh (generally lateral and posterior). Infrequently, pain may radiate into the lateral leg or even more rarely into the foot. In the presence of osteophytes, synovial cysts or facet hypertrophy, radiculopathy may also be present. (Cohen 2007) In 1998, Revel et al. suggested that the presence of the following were helpful in identifying patients with this condition: (1) age > 65; (2) pain relieved when supine; (3) no increase in pain with coughing, hyperextension, forward flexion, rising from flexion or extension/rotation. (Revel, 1998) Recent research has corroborated that pain on extension and/or rotation (facet loading) is a predictor of poor results from neurotomy. (Cohen2, 2007) The condition has been described as both acute and chronic. (Resnick,

2005)

Radiographic findings: There is no support in the literature for the routine use of imaging studies to diagnose lumbar facet mediated pain. Studies have been conflicting in regards to CT and/or MRI evidence of lumbar facet disease and response to diagnostic blocks or neurotomy. (Cohen 2007) See also Facet joint diagnostic blocks (injections); & Segmental rigidity (diagnosis)

Suggested indicators of pain related to facet joint pathology (acknowledging the contradictory findings in current research)

- (1) Tenderness to palpation in the paravertebral areas (over the facet region);
- (2) A normal sensory examination;
- (3) Absence of radicular findings, although pain may radiate below the knee;
- (4) Normal straight leg raising exam

Indicators 2-4 may be present if there is evidence of hypertrophy encroaching on the neural foramen.

This man had central tenderness on the reported exams. The sensory exam was variably reported as normal or abnormal. The reduced ankle jerks suggests this as a sign of a radiculopathy. He had a normal SLR.

Based upon his symptoms and exam, the possibility of the facet as a pain generator has not been proven or disproved.

The next would be the appropriateness of a diagnostic facet injection. The criteria established in the ODG is that the pain should not be radicular. Yet, we can not be sure how much of the pain is from the facet and how much from the disc. The ODG also establishes itself as a guideline and recognizes the role to vary from its criteria. "The publications are guidelines, not inflexible prescriptions and they should not be used as sole evidence for an absolute standard of care. Guidelines can assist clinicians in making decisions for specific conditions...but they cannot take into account the uniqueness of each patient's clinical circumstances.

The Reviewer's medical assessment is that this is one of the cases as there are two possible pain generators. One is referred pain and one may be radicular.

Facet joint diagnostic blocks (injections)

Recommend no more than one set of medial branch diagnostic blocks prior to facet neurotomy, if neurotomy is chosen as an option for treatment (a procedure that is still considered "under study"). Diagnostic blocks may be performed with the anticipation that if successful, treatment may proceed to facet neurotomy at the diagnosed levels. Current research indicates that a minimum of one diagnostic block be performed prior to a neurotomy, and that this be a medial branch block (MBB). Although it is suggested that MBBs and intra-articular blocks appear to provide comparable diagnostic information, the results of placebo-controlled trials of neurotomy found better predictive effect with diagnostic MBBs. In addition, the same nerves are tested with the MBB as are treated with the neurotomy....

The technique for medial branch blocks in the lumbar region requires a block of 2 medial branch nerves (MBN). The recommendation is the following: (1) L1-L2 (T12 and L1 MBN); (2) L2-L3 (L1 and L2 MBN); (3) L3-L4 (L2 and L3 MBN); (4) L4-L5 (L3 and L4 MBN); (5) L5-S1: the L4 and L5 MBN are blocked, and it is recommended that S1 nerve be blocked at the superior articular process. Blocking two joints such as L3-4 and L4-5 will require blocks of three nerves (L2, L3 and L4). Blocking L4-5 and L5-S1 will require blocks of L3, L4, L5 with

the option of blocking S1. (Clemans, 2005) ...

Criteria for the use of diagnostic blocks for facet “mediated” pain

Clinical presentation should be consistent with facet joint pain, signs & symptoms

1. One set of diagnostic medial branch blocks is required with a response of $\geq 70\%$. The pain response should be approximately 2 hours for Lidocaine
2. Limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally
3. There is documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks
4. No more than 2 facet joint levels are injected in one session (see above for medial branch block levels)
5. Recommended volume of no more than 0.5 cc of injectate is given to each joint
6. No pain medication from home should be taken for at least 4 hours prior to the diagnostic block and for 4 to 6 hours afterward
7. Opioids should not be given as a “sedative” during the procedure
8. The use of IV sedation (including other agents such as midazolam) may be grounds to negate the results of a diagnostic block, and should only be given in cases of extreme anxiety
9. The patient should document pain relief with an instrument such as a VAS scale, emphasizing the importance of recording the maximum pain relief and maximum duration of pain. The patient should also keep medication use and activity logs to support subjective reports of better pain control
10. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated. (Resnick, 2005)
11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level.

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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)