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An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: DECEMBER 24, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Bilateral L3-4 and L4-5 Lumbar Spine Facet Block Injection

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

MD, Board Certified in Physical Medicine and Rehabilitation

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.

The reviewer finds that medical necessity does not exist for Bilateral L3-4 and L4-5 Lumbar Spine Facet Block Injection.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 11/18/08, 12/3/08

ODG Guidelines and Treatment Guidelines

, 11/13/08, 4/14/08, 7/15/08

, MD, 11/12/08, 10/16/08, 9/5/08, 8/26/08, 8/20/08, 8/11/08, 7/22/08, 7/16/08, 6/25/08

, DC, 8/14/08, 8/12/08, 7/29/08

MRI Lumbar Spine, 10/30/08, 1/31/08

MRI Cervical Spine, 9/17/07

MRI Thoracic Spine, 9/17/07

Radiology Report, 3/11/08

, MD, 11/5/08

Operative Notes, 2/1/08, 1/11/08
MD, 11/20/08, 10/2/08, 7/9/08
, MD, 10/21/08
COPE, 8/28/08, 7/22/08-7/25/08
, MD, 10/6/08
Dr. , MD, 3/31/08
, PA-C, 3/24/08
, MD, 4/2/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a xx year old man who apparently fell backwards about 10-20 feet off a truck on xx/xx/xx. He was initially evaluated for neck, shoulder and upper to mid back pain. Multiple weights showed him weighing about 300 pounds. There is a note that he had not complained of back pain until the summer of 2008. Yet, he had an MRI (1/31/08) that described a small central disc protrusion at L5/S1 without stenosis, foraminal encroachment on nerve compression. There were no comments on the facets at any level. He apparently had a CT myelogram on 3/11/08 of the lumbar spine that did not show additional problems. He was involved in medical management of his cervical and thoracic pain. These included cervical epidural injections with an associated CSF leak. He had been in a chronic pain program (COPE) in the summer of 2008. He was described as anxious and depressed. The program concentrated on his cervical region.

Dr. wrote (8/11/08) "He says his low back has not really been pursued. He said he hurt in the context of his injury, but it was not included as part of the compensable injury." He then wrote on 8/20/08 that his pain was improving. Dr. 10/16/08 commented that this man said "Dr. told him he had a chip in his back on his xray. He never had any MRI scan on his lower back." Dr. 's examination showed bilateral L5 tenderness with limited flexion and extension. Exam bilateral L5 tenderness. Limited flexion and extension. Dr. (7/29/08) described the patient as "histrionic." He found left L5/S1 hypoesthesias, but otherwise there was no neurological asymmetry. Dr. felt he had facet pain. Dr. (8/14/08) found hypoesthesia in the left L5/S1 region and evidence of right sided unrelated meralgia paresthetica. He found no motor deficits, but there was pain upon loading the L4/5 and L5/S1 facet joints. Dr. performed a Designated Doctor examination on the patient on 10/21/08 and found him to be at MMI with multiple level strains/sprains. Dr. 's DD examination on 3/31/08 did not feel he was at MMI and felt there needed to be further evaluation of his low back pain. The patient had a repeat lumbar MRI on 10/30/08 that showed multiple level degenerative spondylosis with multiple level disc bulges. He had mild bilateral L4/5 foraminal narrowing. There was no comment of facet deterioration. Dr. saw the patient on 11/20/08. He wrote that this man had low back pain radiating to his hips. He described patchy sensation loss in the left lower extremity. He had give way strength testing of the upper extremities, but there was no reported strength testing of the lower extremities. Multiple reports described decreased sensation in the left lower extremity. At times, this was along the medial thigh (L2/L3) other times it was described in the L5/S1 dermatome. Other times it was described as patchy.

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

This patient would appear to meet the ODG criteria of nonradicular back pain at possibly 2 bilateral levels. However, he has not met the third criteria identified in the guidelines of documented failure of conservative treatment. The medications for the upper back

would apply for the lower back, but there was no evidence in the medical records of the patient's participation in a self directed or supervised therapy program. The reviewer finds that medical necessity does not exist for Bilateral L3-4 and L4-5 Lumbar Spine Facet Block Injection.

Facet joint pain, signs & symptoms

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.

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 use of a confirmatory block has been strongly suggested due to the high rate of false positives with single blocks (range of 25% to 40%) but this does not appear to be cost effective or to prevent the incidence of false positive response to the neurotomy procedure itself. ([Cohen, 2007](#)) ([Bogduk, 2000](#)) ([Cohen2, 2007](#)) ([Manchukonda, 2007](#)) ([Dreyfuss, 2000](#)) ([Manchikanti2, 2003](#))

Etiology of false positive blocks: **Placebo response (18-32%)**, use of sedation, liberal use of local anesthetic, and spread of injectate to other pain generators. The concomitant use of sedative during the block can also interfere with an accurate diagnosis. ([Cohen, 2007](#))

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