Applied Assessments LLC

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Notice of Independent Review Decision

DATE OF REVIEW: March 25, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar Facet Block at L4-5 and L5-S1

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

M.D., Board Certified Orthopedic Surgeon

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)

Upon independent review the reviewer finds that the requested Lumbar Facet Block at L4-5 and L5-S1 is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Office notes, Dr. 01/02/02, 01/09/02, 01/16/02, 01/30/02, 02/13/02, 02/27/02, 03/13/02, 04/02/02, 05/01/02, 05/29/02, 07/24/02, 09/18/02, 11/13/02, 01/08/03, 07/16/03, 10/07/03, 11/04/03, 02/24/04, 04/21/04, 06/16/04, 08/11/04, 10/06/04, 12/01/04, 01/26/05, 03/23/05, 05/18/05, 07/20/05, 09/14/05, 11/09/05, 01/17/06, 03/16/06, 05/10/06, 07/12/06, 09/06/06, 11/01/06, 01/04/07, 04/26/07, 06/21/07, 08/16/07, 10/23/07, 12/19/07
Lumbar MRI, 02/05/02, 08/20/03
Procedure report, Lumbar epidural steroid injection, 03/20/02, 04/09/02, 01/06/04, 06/08/04

Impairment evaluation record, 05/23/02
Medical evaluation, Dr. 10/02/02
Medical evaluation, Dr. , 02/24/03
Required Medical evaluation, Dr. 07/09/03, 06/21/06
Office notes, Dr. 11/03/03, 11/17/03, 01/09/04, 03/29/04, 04/26/04, 05/17/04, 06/28/04, 12/06/04, 12/27/04, 02/21/05, 03/21/05, 04/18/05, 05/16/05, 08/01/05, 08/17/05, 09/26/05, 11/11/05, 12/09/05, 01/11/06, 02/15/06, 03/29/06, 05/10/06, 06/14/06, 07/06/06, 07/26/06, 09/06/06, 11/06/06, 12/29/06, 02/28/07, 05/29/07, 06/13/07, 07/11/07, 09/12/07, 12/05/07, 02/06/08, 02/20/08
Lumbar discogram/CT scan report, 12/04/03
Procedure report, Dr. bilateral L4-5 and L5-S1 facet blocks, 09/14/04, 02/01/05, 07/05/05, 03/07/06, 07/18/06, 08/22/06, 12/15/06
Operative report, Dr. 10/24/05, 11/01/05, 12/01/05
Procedure report right SI joint injection, 06/19/07
Adverse Determination Letters, 01/13/08, 02/15/08
ODG Guidelines and Treatment Guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:

This male injured his low back at work. He treated with Orthopedist Dr. since that time and he has treated with Dr. since November 2003. The claimant had lumbar MRI studies in 2002 and 2003 as well as a CT/discogram in 2003. He was treated with epidural steroid injections as well as bilateral L4-5 and L5-S1 facet blocks in 2004 and 2005 with good relief of symptoms. As of 02/21/05 the claimant was noted to have had 85 percent relief with facet blocks. On 10/24/05 Dr. performed a selective endoscopic discectomy with annuloplasty of L3-4; on 11/01/05 a selective endoscopic discectomy with annuloplasty of L4-5 and re-exploration of right L5 nerve root and on 12/01/05 he performed a selective endoscopic discectomy with annuloplasty of L5-S1 and right L5-S1 neuro foraminoplasty.

At the 01/11/06 visit with Dr. the claimant no longer had any lower extremity radicular symptoms but the lumbar pain was still present. The claimant had additional bilateral L4-5 and L5-S1 facet injections on 03/07/06, 07/18/06, 08/22/06 and 12/15/06 with up to 75 percent relief of symptoms.

On 02/27/07 Dr. noted that the claimant had returned to work. Medications were Lidoderm patches, ibuprofen and Prevacid. On 05/29/07 the claimant was still working but after extended periods of walking, had developed progressive intermittent pain more on the right through the lumbosacral region. The lower extremity neurological exam was intact with a bilateral straight leg raise test and a bilateral Patrick's, right greater than left. There was also a bilateral pelvic tilt, right greater than left. The diagnoses were lumbago, lumbar radiculopathy, lumbar internal disc derangement and bilateral sacroiliitis, right greater than left. A right sacroiliac injection was given. At the 07/11/07 and 09/12/07 visits the claimant was doing well. Medications were ibuprofen, Prevacid, Xanax and Fioricet.

On 12/05/07 Dr. noted complaints of right sided lumbosacral pain and mid lumbar pain that escalated with activities. The claimant had guarded lumbar motion, tenderness of the paraspinous muscles and right lumbar sacral region. There was a positive right sided pelvic tilt test and positive right Spurling's as well as a positive right Patrick's. Lower extremity neurological exam was intact with a positive right straight leg raise and hyperreflexia bilaterally of the patellar region. The diagnoses were lumbago, lumbar radiculopathy, lumbar internal disc

derangement, right sacroiliitis and lumbar spondylosis. A facet block was recommended but denied on peer reviews dated 01/13/08 and 02/15/08.

Office notes from Dr. dated 02/06/08 documented pain with extension and rotation of the back with some radiation of pain from the low back into the right buttock and occasionally into the lateral thigh and into the anterior lower leg. On exam Patrick's sign was negative bilaterally, extension and rotation of lumbar spine was painful. Lumbar facets were tender in the lower back. Extension from a bent forward position was also painful. Bilateral lower extremity neurological exam was intact and straight leg raise was negative. X-rays showed an anterior spur at L5-S1 and some decreased disc height of L4-5 and L5-S1. There was some vacuum phenomena of L4-5 and there was facet arthropathy of L4-5 and L5-S1. The diagnosis was lumbago, lumbar radiculopathy, right sacroiliitis. The physician indicated that the claimant had at least 80 % relief with previous L4-5 and L5-S1 facet blocks and that the claimant had done very well with injections in the past. Dr. indicated in a report dated 02/20/08 that the claimant had constant mid lumbar pain with painful range of motion that exacerbated easily on extension, bilateral rotation and bilateral tilt. There was tenderness of the paraspinous muscles, painful bilateral straight leg raise and positive bilateral Patrick's sign. The diagnoses were lumbago, lumbar spondylosis, bilateral sacroiliitis and lumbar internal disc derangement. He felt that the claimant met the criteria for facet blocks.

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

Based on this medical record, I do not see the medical indication for the requested lumbar facet block, L4-5 and L5-S1.

When I review this medical record, the claimant is a gentleman who has had previous lumbar surgery. He has had numerous facet blocks which give reasonable relief for appropriate length of time. Over time the relief fades, and he then undergoes another series of injections.

In this case, the best possible method of treatment is not another facet block, which has shown to give only temporary relief in the past.

While I do not disagree with Dr. that the previous blocks have given relief, ODG Guidelines indicate treatment more definitive in an attempt to give longer lasting relief.

Official Disability Guidelines Treatment in Worker's Comp 2008 Updates, Low Back.
Facet joint intra-articular injections (therapeutic blocks)
Under study. Current evidence is conflicting as to this procedure and at this time no more than one therapeutic intra-articular block is suggested. If successful (pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive). If a therapeutic facet joint block is undertaken, it is suggested that it be used in consort with other evidence based conservative care (activity, exercise, etc.) to facilitate functional improvement. (Dreyfuss, 2003) (Colorado, 2001) (Manchikanti , 2003) (Boswell, 2005) See Segmental rigidity (diagnosis). In spite of the overwhelming lack of evidence for the long-term effectiveness of intra-articular steroid facet joint injections, this remains a popular treatment modality. Intra-articular facet joint injections have been popularly utilized as a therapeutic procedure, but are not currently recommended as a treatment modality in most evidence-based reviews as their benefit remains controversial. The therapeutic facet joint injections described here are injections of a steroid

(combined with an anesthetic agent) into the facet joint under fluoroscopic guidance to provide temporary pain relief. (Dreyfuss, 2003) (Nelemans-Cochrane, 2000) (Carette, 1991) (Nelemans, 2001) (Slipman, 2003) (van Tulder, 2006) (Colorado, 2001) (ICSI, 2004) (Bogduk, 2005) (Resnick, 2005) (Airaksinen, 2006)

Systematic reviews endorsing therapeutic intra-articular facet blocks:

Pain Physician, 2005: In 2005 there were two positive systematic reviews published in *Pain Physician* that stated that the evidence was moderate for short-term and limited for long-term improvement using this intervention. (Boswell, 2005) (Boswell, 2005) These results were based, in part, on five observational studies. These non-controlled studies were confounded by variables such as lack of confirmation of diagnosis by dual blocks and recording of subjective pain relief, or with measures that fell under verbal rating and/or pain relief labels (measures that have been reported to have problems with validity). (Edwards, 2005)

Pain Physician, 2007: Pain Physician again published a systematic review on this subject in 2007 and added one additional randomized trial comparing intra-articular injections with sodium hyaluronate to blocks with triamcinolone acetonide. The diagnosis of facet osteoarthritis was made radiographically. (Fuchs, 2005) Two randomized trials were not included, in part, as they failed to include controlled diagnostic blocks. These latter articles were negative toward the use of therapeutic facet blocks. (Lilius, 1989) (Marks, 1992) An observational non-controlled study that had positive results was included that made the diagnosis of lumbar facet syndrome based on clinical assessment of “pseudoradicular” lumbar pain, including evidence of an increase of pain in the morning and with excessive stress and exercise (no diagnostic blocks were performed). (Schulte, 2006) With the inclusion of these two articles the conclusion was changed so that the evidence for lumbar intra-articular injections was “moderate” for both short-and long-term improvement of low back pain. (Boswell2, 2007)

Complications: These included suppression of the hypothalamic-pituitary-adrenal axis for up to 4 weeks due to steroids with resultant elevated glucose levels for less than a week. (Ward, 2002) There have been rare cases of infection (septic arthritis, epidural abscess and meningitis). (Cohen, 2007) Complications from needle placement include dural puncture, spinal cord trauma, intraarterial and intravenous injection, spinal anesthesia, neural trauma, pneumothorax, and hematoma formation. (Boswell2, 2007)

Single photon emission computed tomography: (bone scintigraphy, SPECT scan): Not recommended although recent research is promising. This technique is recommended based on the ability of radionuclide bone scintigraphy to detect areas of increased function, depicting synovial areas of inflammation as well as degenerative changes. Thirteen of 15 patients had a > 1 standard deviation pain score improvement at 1 month versus 7 of 32 patients with a negative or no scan. The benefit of the injection lasted for approximately 3 months and did not persist to 6 months. (Pneumaticos2, 2006) See also Facet joint diagnostic blocks (injections); Facet joint pain, signs & symptoms; Facet joint radiofrequency neurotomy; Facet joint medial branch blocks (therapeutic injections); & Segmental rigidity (diagnosis). Also see Neck Chapter and Pain Chapter.

Criteria for use of therapeutic intra-articular and medial branch blocks, are as follows:

1. No more than one therapeutic intra-articular block is recommended.
2. There should be no evidence of radicular pain, spinal stenosis, or previous fusion.
3. If successful (pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive).
4. No more than 2 joint levels may be blocked at any one time.
5. There should be evidence of a formal plan of additional evidence-based activity and exercise in addition to facet joint injection therapy.

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)