

SENT VIA EMAIL OR FAX ON
Feb/10/2009

Pure Resolutions Inc.

An Independent Review Organization
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DATE OF REVIEW:
Feb/05/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
facet joint injection at right L3/4, L4/5, L5/S1

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 12/29/08 and 1/13/09
Record from Anesthesia and Pain 12/12/08
Record from Dr. 12/16/08

PATIENT CLINICAL HISTORY SUMMARY

This is a xx year old lady injured on xx/xx/xx. She had low back pain going to her leg. She had chiropractic care and multiple epidural injections. Her right ankle jerk was absent, otherwise the neurological examination was intact. She had lower facet tenderness. She had two MRIs in 2006. These showed a central disc protrusion at L5/S1 abutting the S1 root bilaterally. Facet hypertrophy was found. There was also an L4/5 disc bulge. She had a discogram in 2006, but the results were not provided. An EMG in 2005 was cited as showing a chronic L5 radiculopathy. She apparently had a L4/5 and L5/S1 discectomy in October 2006. A fusion was considered for 2008, but denied.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS

AND CONCLUSIONS USED TO SUPPORT THE DECISION

First, does she have facet pain? The Reviewer is not sure from reading the records that she has pain in the facet referred distribution. She has had pain down her right leg to her heel. The suggested indicators are a normal sensory examination, local facet tenderness, a normal SLR. She has these, but she also has pain down the right leg to her heel. This would suggest that she may not have facet pain.

Facet joint pain, signs & symptoms

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.

Intra-articular injections are a source of conflict in the ODG. It does note that the procedure should not be performed if there was a prior fusion, which she has not had. It should not be performed when there is evidence of radicular pain. She describes the pain down her right leg to her heel. Further, the MRI described suggest some spinal stenosis, although the actual report was not provided. Lastly, no more than 2 levels may be injected. Three were requested. For these reasons, the Reviewer can not over rule the prior decision.

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)...

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 (initial pain relief of 70%, plus 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-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)