



Medical Review Institute of America, Inc.
America's External Review Network

DATE OF REVIEW: September 18, 2009

IRO Case #:

Description of the services in dispute:

1) Review Left L4-5, L5-S1 Lumbar facet in the office.

A description of the qualifications for each physician or other health care provider who reviewed the decision

The physician who provided this review is board certified by the American Board of Physical Medicine & Rehabilitation in General Physical Medicine & Rehabilitation and Pain Medicine. This reviewer has been in active practice since 2005.

Review Outcome

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld

The patient has undergone prior epidural steroid injections as well as facet injections. The patient has not shown substantial improvement with any injections or invasive pain management techniques. The patient did report 50% improvement with the lumbar facet injections and agreement is made with the prior review that the patient should now proceed with neurotomy or rhizotomy. The patient does not require subsequent facet injections.

Information provided to the IRO for review

Records from State:

Request for a Review by an Independent Review Organization 8/31/09 (3 pages)

ODG Guidelines Facet Injections (5 pages)

Preauthorization Request from Consultants 8/27/09 (2 pages)

Office Notes from Dr. 10/30/08-8/27/09 (30 pages)

MRI Lumbar Spine from Imaging Center 4/3/08 (2 pages)

Review denying services 8/4/09, 8/19/09 (4 pages)

Physician List with Dr. 's information (1 page)

Patient clinical history [summary]

The patient is a female whose date of injury is xx/xx/xx. The clinical notes dating back to October 2008 show the patient has had back and bilateral lower extremity pain, left greater than right. According to the 10/30/2008 note, the patient underwent epidural block with improvement on the right side with continued left sided pain. The patient was taking Mobic, Neurontin, Norco, and Robaxin. The patient was recommended for Zanaflex and was planned for a repeat epidural steroid injection. Clinical note dated 11/10/2008 indicates the patient was inquiring regarding percutaneous discectomy. The patient was initiated on Pristiq and was noted to not be a candidate for percutaneous discectomy due to the multiple abnormalities contributing to radicular problems. The patient was scheduled for a 3rd epidural steroid injection on 11/11/2008. The procedure note dated 11/11/2008 indicates the patient underwent a left sided epidural steroid injection at 2 levels. The patient was seen on follow up on 11/25/2008 noting left side is feeling better, and now the right side is having increased pain. The patient was recommended for continued medication use and physical therapy. The note dated 03/02/2009 indicates the patient was scheduled for a consult with neurosurgery, noting having had a series of epidural steroid injections without improvement. MRI of the lumbar spine was carried out on 04/03/2008 which noted minimal loss of disc signal at L1-2, L3-4, with moderate loss of disc signal at L2-3. At L4-5 there was evidence of ligamentous thickening and facet hypertrophy and moderate left greater than right disc bulge. At L5-S1 there was moderate loss of disc signal with 2mm central disc bulge and mild thickening of the ligamentum flavum. The findings were noted to be mostly mild in nature. On follow up dated 05/18/2009 the patient continued to complain of bilateral low back pain with referral into the lower extremities. The patient was recommended for surgery and was recommended for follow up post procedure. The patient was recommended for sacroiliac injections under fluoroscopy. The patient underwent SI joint injections on 06/08/2009, with 45% relief for "a couple of days". The patient was scheduled for a lumbar block at L4-5, L5-S1 on the right. The patient was seen on 06/30/2009 and underwent injections. On a follow up the patient reported 50% improvement on the right. The patient had 2 prior reviews for paravertebral injections #64475. The first review denied facet injections, as it did not meet ODG Guidelines. Noting that the patient had success and should proceed with neurotomy. Subsequent review dated 08/19/2009 noting that non-certification based on the first review should be upheld, noting that repeat facet injections are not medically necessary.

Analysis and explanation of the decision include clinical basis, findings and conclusions used to support the decision.

The patient has undergone prior epidural steroid injections as well as facet injections. The patient has not shown substantial improvement with any injections or invasive pain management techniques. The patient did report 50% improvement with the lumbar facet injections and agreement is made with the prior review that the patient should now proceed with neurotomy or rhizotomy. The patient does not require subsequent facet injections.

A description and the source of the screening criteria or other clinical basis used to make the decision:

1. Official Disability Guidelines, low back chapter, online version

Facet joint injections, thoracic. Not recommended. There is limited research on therapeutic blocks or neurotomies in this region, and the latter procedure (neurotomies) are not recommended. Recent publications on the topic of therapeutic facet injections have not addressed the use of this modality for the thoracic region. (Boswell, 2005) (Boswell2, 2005) Pain due to facet joint arthrosis is less common in the thoracic area as there is overall less movement due to the attachment to the rib cage. Injection of the joints in this region also presents technical challenge. A current non-randomized study reports a prevalence of facet joint pain of 42% in patients with chronic thoracic spine pain. This value must be put into perspective with the overall frequency of chronic pain in the cervical, thoracic and lumbar region. In this non-randomized study, 500 patients had 724 blocks. Approximately 10% of the blocks were in the thoracic region, with 35.2% in the cervical region and 54.8% in the lumbar. (Manchikanti, 2004)