

# Clear Resolutions Inc.

An Independent Review Organization  
7301 RANCH RD 620 N, STE 155-199A  
Austin, TX 78726  
Phone: (512) 772-4390  
Fax: (512) 519-7316  
Email: resolutions.manager@cri-iro.com

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Nov/24/2010

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Left lumbar facet block @L3-4, L4-5, TIVA Anesthesia

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

MD, Board Certified in Physical Medicine and Rehabilitation  
Board Certified in Pain Management

**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**

Official Disability Guidelines

The 11/4/10, 10/22/10

MD 1/3/10 to 10/14/10

Diagnostic 2/9/10, 9/20/10

HealthCare Associates 1/4/10 to 10/25/10

Neurodiagnostic Associates, Inc. 6/15/10

Orthopedic Group LLP 7/15/10, 6/3/10

Associated, PA 1/5/10

MRI 2/19/02

MRI and Diagnostic 4/22/10

Brain & Spine Insistute 8/17/10

M.D. 10/25/10

**PATIENT CLINICAL HISTORY SUMMARY**

This is a man reportedly injured on xx/xx/xx when he attempted to restrain a dog working in a xxxx. He developed low back pain. His pain drawing showed bilateral low back and lower extremity pain. His MRI on 2/9/10 showed an L3/4 and L4/5 HNP with an annular tear in the lower space. There were comments of an L4/5 protrusion in a 2002 MRI. Dr. noted that he had bilateral back pain going more to the left than the right lower extremity. There was local tenderness at the L3/4 and L4/5 spinous processes and at the L3/4 and L4/5 facet region. He had positive bilateral SLR with reduced left lower extremity strength, generalized hyperalgesia and absent left ankle jerk. An EMG (6/15/10) was reported a being consistent

with a left L5 radiculopathy based upon left lumbar paraspinal polyphasic activities. Dr. felt he had a disc problem and suggested surgery. Dr. (8/17) did not feel the physical findings were consistent with the MRI and did not advise any surgery. Dr. performed a translaminar ESI in 4/10 that Dr described only 3 days of relief. Dr. wrote that "the patient has severe radiculopathy." He wanted to address the left lumbar pain with facet blocks. Several doctors described psychological stress.

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

The first requirement for the facet injection is the presence of facet pain. This requires local tenderness, (present), a normal sensory exam (absent), normal SLR (absent) and absent radicular findings (which are present). Based upon this information and description, he has radicular issues as Dr. noted. He does not meet the requirements for facet pain. Further, diagnostic facet injections/blocks are not to be performed when there is radicular pain. Several doctors described radicular pain. Based upon this information, this man does not meet the criteria for facet pain and a facet block. Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be upheld. The reviewer finds no medical necessity for Left lumbar facet block @L3-4, L4-5, TIVA Anesthesia.

#### 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 medicated 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) Degenerative changes in facets identified by CT do not correlate with pain and are part of the natural degenerative process. (Kalichman, 2008) See also Facet joint diagnostic blocks (injections); & Segmental rigidity (diagnosis).

**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 REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

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