

## Notice of Independent Review Decision

**DATE OF REVIEW:** MAY 18, 2010

**IRO CASE #:** 27002

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

Outpatient right lumbar L3-4, L4-5 facet injections using medial branch block technique and trigger point injections.

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

The physician reviewing this case is American Board Certified in Anesthesiology with a secondary specialty 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 (Disagree 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.

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

The examinee continued treatment with, D.C. from xxxxxx to 3/8/10 with only 18% improvement documented over 13 visits.

### **PATIENT CLINICAL HISTORY:**

The claimant is employed as an executive assistant, who injured her lumbar spine when she tripped over a curb falling on her buttocks.

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

The review of the medical records, especially the MRI of the Lumbar spine, does not indicate sufficient reason for a positive response to right side L3-4 and L4-5 facet injections using medial branch block technique and trigger point injections.

Despite the relative simplicity of these blocks, they are invasive procedures, and thus may not be performed unless there is a reasonable basis for a successful outcome.

The physical findings are consistent with possible S1 radiculopathy. Therefore, I concur with the denial of the procedure. The previous decisions are upheld.

<p>Facet joint diagnostic blocks (injections)</p>	<p><b>Criteria for the use of diagnostic blocks for facet “mediated” pain:</b>  Clinical presentation should be consistent with <a href="#">facet joint pain, signs &amp; symptoms</a>.</p> <ol style="list-style-type: none"> <li>1. One set of diagnostic medial branch blocks is required with a response of <math>\geq 70\%</math>. The pain response should be approximately 2 hours for Lidocaine.</li> <li>2. Limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally.</li> <li>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.</li> <li>4. No more than 2 facet joint levels are injected in one session (see above for medial branch block levels).</li> <li>5. Recommended volume of no more than 0.5 cc of injectate is given to each joint.</li> <li>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.</li> <li>7. Opioids should not be given as a “sedative” during the procedure.</li> <li>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.</li> <li>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.</li> <li>10. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated. (<a href="#">Resnick, 2005</a>)</li> <li>11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. [Exclusion Criteria that would require UR physician review: Previous fusion at the targeted level. (<a href="#">Franklin, 2008</a>)]</li> </ol>
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<p>Trigger point</p>	<p><b>Criteria for the use of Trigger point injections:</b></p>
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injections (TPIs)	<p>Trigger point injections with a local anesthetic with or without steroid may be recommended for the treatment of chronic low back or neck pain with myofascial pain syndrome when all of the following criteria are met: (1) Documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain; (2) Symptoms have persisted for more than three months; (3) Medical management therapies such as ongoing stretching exercises, physical therapy, NSAIDs and muscle relaxants have failed to control pain; (4) Radiculopathy is not present (by exam, imaging, or neuro-testing); (5) Not more than 3-4 injections per session; (6) No repeat injections unless a greater than 50% pain relief with reduced medication use is obtained for six weeks after an injection and there is documented evidence of functional improvement; (7) Frequency should not be at an interval less than two months; (8) Trigger point injections with any substance (e.g., saline or glucose) other than local anesthetic with or without steroid are not recommended; (9) There should be evidence of continued ongoing conservative treatment including home exercise and stretching. Use as a sole treatment is not recommended; (10) If pain persists after 2 to 3 injections the treatment plan should be reexamined as this may indicate an incorrect diagnosis, a lack of success with this procedure, or a lack of incorporation of other more conservative treatment modalities for myofascial pain. It should be remembered that trigger point injections are considered an adjunct, not a primary treatment.</p>
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Facet joint medial branch blocks (therapeutic injections)	<p>Not recommended except as a diagnostic tool. Minimal evidence for treatment.</p> <p><i>Pain Physician 2005:</i> In 2005 <i>Pain Physician</i> published an article that stated that there was moderate evidence for the use of lumbar medial branch blocks for the treatment of chronic lumbar spinal pain. (<a href="#">Boswell, 2005</a>) This was supported by one study. (<a href="#">Manchikanti, 2001</a>) Patients either received a local anesthetic or a local anesthetic with methyl prednisolone. All blocks included Sarapin. Sixty percent of the patients overall underwent seven or more procedures over the 2½ year study period (<math>8.4 \pm 0.31</math> over 13 to 32 months). There were more procedures recorded for the group that received corticosteroids than those that did not (301 vs. 210, respectively). [“Moderate evidence” is a definition of the quality of evidence to support a treatment outcome according to <i>Pain Physician</i>.] The average relief per procedure was <math>11.9 \pm 3.7</math> weeks.</p> <p><i>Pain Physician 2007:</i> This review included an additional randomized controlled trial. (<a href="#">Manchikanti2, 2007</a>) Controlled blocks with local anesthetic were used for the diagnosis (80% reduction of pain required). Four study groups were assigned with 15 patients in each group: (1) bupivacaine only; (2) bupivacaine plus Sarapin; (3) bupivacaine plus steroid; and (4) bupivacaine, steroid and Sarapin. There was no placebo group. Doses of 1-2ml were utilized. The average number of treatments was 3.7 and there was no significant difference in number of procedures noted between the steroid and non-steroid group. Long-term improvement was only thought to be possible with repeat interventions. All groups were significantly improved from baseline (a final Numeric Rating Scale score in a range from 3.5 to 3.9 for each group). Significant improvement occurred in the Oswestry score from baseline in all groups, but there was also no significant difference between the groups. There was no significant difference in opioid intake or employment status. There was no explanation posited of why there was no difference in results between the steroid and non-steroid groups. This study was considered positive for both short- and long-term relief, although, as noted, repeated injections were required for a long-term effect. Based on the inclusion of this study the overall conclusion was changed to suggest that the evidence for therapeutic medial branch blocks was moderate for both short- and long-term pain relief. (<a href="#">Boswell2, 2007</a>)</p> <p>Psychiatric comorbidity is associated with substantially diminished pain relief after a medial branch block injection performed with steroid at one-month follow-up. These findings illustrate the importance of assessing comorbid psychopathology as part of a spine care evaluation. (<a href="#">Wasan, 2009</a>) The use of the blocks for diagnostic purposes is discussed in <a href="#">Facet joint diagnostic blocks</a> (injections). See also <a href="#">Facet joint intra-articular</a></p>
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**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)