

Becket Systems

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Feb/06/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left lumbar facet injection L4-L5 under anesthesia and fluoroscopy

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

MD, 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Workers' Comp Services, 1/12/11, 12/20/10

Office notes, physician unknown, 09/20/10, 09/23/10,

Prescriptions, Dr., 09/20/10, 09/21/10

Radiology Reports, 09/21/10

MRI Lumbar Spine, 09/22/10

Office notes, Dr., 09/27/10, 10/04/10

MRI pelvis/bilateral hips, 09/29/10

Initial Physical Therapy Note, 10/05/10

Office Notes, Dr., 10/19/10, 12/01/10, 12/13/10

Medical questionnaire, 10/21/10

Office Note and electrodiagnostic report, Dr., 10/22/10

Triple Phase Bone Scan, 11/29/10

CT Lumbar Spine, 12/09/10

Review, Dr., 12/20/10

Review, Dr. 01/12/11

Phone Conference, 01/24/11

Official Disability Guidelines Treatment in Worker's Comp, 16th edition, 2011 Updates, Low Back Chapter, Facet Injection

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female who fell at work when her foot was hung up in a pallet on xx/xx/xx. She was seen that day and had slight tenderness of the left buttock, decreased strength, reflexes and sensation of the lower extremity. An L5 disc extrusion was diagnosed.

Radiology reports on 09/21/10 of the pelvis, left femur and left hip were negative for fractures.

A lumbar MRI on 09/22/10 showed mild spinal canal stenosis at L4-5. The claimant

presented to Dr. on xx/xx/xx for left hip pain which was worse with certain positions with a

little bit of radiation down into the thigh, but not down into the leg and a feeling of fatigue of the left leg. The examination showed a mild antalgic limp on the left, mild tenderness over the left SI (sacroiliac) joint with more exquisite tenderness over the left greater trochanter, pain in the hip girdle, intact sensation, low back pain at 70 degrees with straight leg raise and exquisitely positive Fabere test. A contusion of the left hip was diagnosed. Flexor patches were prescribed. An MRI of the pelvis and bilateral hips on 09/29/10 revealed no acute osseous abnormality and no fracture, contusion or avascular necrosis. There was an indeterminate, but nonaggressive 1.7 x 2.8 x 1.5 centimeter lesion within left hip intertrochanteric medullary cavity which notes indicate may represent a low-grade cartilage lesion such as an enchondroma or low-grade fibrous lesion. There was also mild bilateral gluteus medius and left gluteus minimus tendinosis.

Dr. re-evaluated the claimant on 10/04/10 for intermittent pain in the hip going down a little into the lateral thigh. She reportedly had been told by an orthopedic surgeon that the MRI showed some sort of fatty tumor in the left leg. Therapy and Arthrotec were recommended. Dr. saw the claimant on 10/19/10 for ongoing left hip pain. There was difficulty with transitional movements, lumbar tenderness to palpation, moderate restriction of motion all planes, pain in the back and buttock only with left straight leg raise, tenderness over the left greater trochanter, mild restriction in flexion, extension, adduction and internal rotation with hip motion and minimal pain with logrolling. There was tenderness along the iliotibial band, a mild left antalgic gait, grade 3+/5 tibialis anterior and 4/5 extensor hallucis longus strength on the left and sensory loss in the lateral thigh on the left. Persistent left sciatica was diagnosed.

The 10/22/10 examination by Dr. showed that she appeared to be off-loading the left hip, tenderness to palpation of the left SI joint, over the left sciatic notch, left iliolumbar triangle and over the left greater trochanter. Reflexes were 2+ at the knees and right ankle and 1+ of the left ankle. Straight leg raise was positive on the left for pain. EMG studies that day were incomplete due to her intolerance of the needle exam. There was no convincing electrophysiologic evidence of lumbosacral radiculopathy or plexopathy. There was mild increased polyphasicity of questionable clinical significance, but may represent lumbar radicular source. There was no electrophysiologic evidence of generalized peripheral neuropathy based on nerve conduction study values. A triple phase bone scan and whole body bone scan with tomographic imaging of the lumbar spine on 11/29/10 showed focally intense left posterior element reactivity at L4-5 with probable associated hyperemia, suggestive of fracture. A lumbar CT on 12/09/10 showed the area of abnormal uptake seen on the bone scan corresponded to advanced asymmetric degenerative arthrosis of the left L4-5 facet joint. No pars defect or fracture were identified.

The 12/13/10 examination was unchanged. Facet syndrome was diagnosed and Dr. recommended a single medial branch block at L4-5 on the left to determine if that was the sole source of her pain. Reviews on 12/20/10 and 01/12/11 denied the left lumbar facet injection. A phone conference on 01/24/11 with Dr. indicated the claimant had unbearable leg pain and hypersensitivity. Ultracet was prescribed.

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

The requested Left lumbar facet injection L4-L5 under anesthesia and fluoroscopy is medically necessary in an attempt to determine whether or not this claimant in fact is having left L4-5 facet joint pain.

This is a woman who has had ongoing low back and left leg complaints following a fall, xx/xx/xx. She has undergone a complete workup which only points to abnormality at the left L4-5 facet joint as showing significant arthritis on bone scan and CAT scan testing. Her physician has requested an L4-5 facet block to see whether or not that in fact takes care of her pain, which would then indicate this in fact was the anatomic problem. She was injured more than four months ago and has already had therapy, activity modification, and medication without improvement.

Official Disability Guidelines document the use of a diagnostic facet block in an attempt to determine whether or not someone has facet joint pain, and it would appear to this reviewer that the requested block falls within these guidelines. Therefore, in light of the fact that the treating physician is only trying to determine whether or not the L4-5 facet joint is painful since it is abnormal on diagnostic testing, and the claimant has failed other trials of conservative care, then the requested Left lumbar facet injection L4-L5 under anesthesia and fluoroscopy for diagnosis is medically necessary.

Official Disability Guidelines Treatment in Worker's Comp, 16th edition, 2011 Updates, Low Back Chapter, Facet Injection

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

Criteria for the use of diagnostic blocks for facet "mediated" pain

Clinical presentation should be consistent with facet joint pain, signs & symptoms

1. One set of diagnostic medial branch blocks is required with a response of $\geq 70\%$. The pain response should be approximately 2 hours for Lidocaine
2. Limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally
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
4. No more than 2 facet joint levels are injected in one session (see above for medial branch block levels)
5. Recommended volume of no more than 0.5 cc of injectate is given to each joint
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
7. Opioids should not be given as a "sedative" during the procedure
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
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

10. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated. (Resnick, 2005)

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. (Franklin, 2008)]

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)