

AccuReview
An Independent Review Organization
(817) 635-1824 (phone)
(817) 635-1825 (fax)
Notice of Independent Review Decision

DATE OF REVIEW: JUNE 23, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar Facet Injections (PNR EMG) 62311

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

This physician is a Board Certified Neurological Surgeon with over 40 years of experience.

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)

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

January 24 – March 2, 2011: Mr. underwent physical therapy at Clinic.

February 28, 2011: MRI of Lumbar Spine: Impression (read by MD): Height of vertebral bodies and marrow signal intensities show no evidence fracture, tumor, metastatic disease or bone contusion. Alignment is anatomical. Conus medullaris, cauda equina and filum terminale show no evidence of space occupying lesion, edema or mass effect. Size configuration, signal intensities and location are normal. Conus is T12.

March 22, 2011: Mr. was examined by Dr., M.D. Dr. recommended Mr. have an EMG and facet injections. He prescribed him Norco 5/325 mg. He also prescribed Mr. a lumbosacral corset.

March 24, 2011: Dr. supplemented his report from March 22, 2011. By reviewing the MRI films, he felt that Mr. had intervertebral disc displacement at L4-5 with spinal stenosis at L4-5.

April 11, 2011: Dr., DO, did a review for adverse determination on Mr.. She concluded that based on the clinical information submitted for the review and using evidence-based, peer reviewed guidelines, the request for lumbar facet injections was not certified.

May 19, 2011: Dr., MD Neurosurgery, did a review for reconsideration for adverse determination on Mr.. He concluded that based on the clinical information submitted for the review and using evidence-based, peer-reviewed guidelines, the appeal for Lumbar Facet Injections was partially certified (certification is recommended for the requested EMG. Certification is not recommended for the requested Lumbar Facet Injections).

May 13, 2011: Dr. did an electrodiagnostic consultation on Mr.. The impression was no conclusive electrodiagnostic evidence of a right or left L3-S1 radiculopathy. No conclusive electrodiagnostic evidence of peripheral polyneuropathy.

May 24, 2011: Dr. supplemented his report. He received a hand written EMG which was normal in both lower extremities right and left. He still recommended that Mr. had the facet injections and ESIs.

PATIENT CLINICAL HISTORY:

The claimant is XX years old.

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

The EMG that was performed on May 13, 2011 was negative for radiculopathy. There is no documentation of weakness in the lower extremities and pinprick sensation is intact. Based on the ODG the claimant does not meet the criteria for a lumbar facet injection; therefore the previous decisions are upheld.

Per the ODG:

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 last at least 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](#))]

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- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGBASE
- 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)