



CLAIMS EVAL

*Utilization Review and
Peer Review Services*

Notice of Independent Review Decision-WC

DATE OF REVIEW: 3-2-11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient Medial Branch Block

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

American Boards of Physical Medicine and Rehabilitation and 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)

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

- Healthcare System-Emergency Room, MD.
- X-ray of the lumbar spine, pelvis and left elbow performed by , MD.
- Chiropractic Therapy at Chiropractic Center on 9-6-02, 9-9-02, 9-11-02, 9-13-02, 9-20-02, 9-26-02.
- 1-3-03 MRI of the lumbar spine without contrast performed by MD., showed.
- Physical Therapy at Physical Therapy and Rehabilitation on 2-6-03, 2-7-03, 2-11-03, 2-13-03, 2-18-03, 2-19-03, 2-20-03.
- Physical Therapy at Physical Therapy and Rehabilitation on 3-20-03, 3-21-03, 3-25-03, 3-27-03, 3-28-03, 4-1-03, 4-3-03, 4-4-03, 4-8-03, 4-10-03, 4-11-03, 4-15-03, 4-22-03, 4-25-03, 5-15-03, 5-20-03.
- 5-20-03 DO., Medical Review.
- 9-17-03, 9-21-07, 5-3-08, 10-24-08 MD., injections.
- 10-13-03 MD., Required Medical Evaluation.
- 10-17-03, 1-25-10 MD., Independent Medical Evaluation.
- 11-4-03, 12-11-03, 10-15-05, and 6-26-06 MD., office visits.
- 2-15-05, 3-18-05, and 6-16-05 MD., office visits.
- 3-10-05 MRI of the pelvis and left hip performed by MD.
- 4-5-05, 5-23-05 MD., office visits.
- 5-23-05 MRI of the lumbar spine performed by MD.
- 7-11-05 MD., Impairment Rating.
- 12-2-05, 1-20-06, 11-13-09 MD., Medical Review.

- 12-22-06 MD., office visit.
- 11-18-08, 2-2-09 MD., office visits.
- 12-17-08 R. MD., surgery.
- 3-17-09 MD., office visit.
- 12-21-10 MD., office visit.
- 12-27-10 MD., performed a Utilization Review.
- 1-18-11 MD., performed a Utilization Review.

PATIENT CLINICAL HISTORY [SUMMARY]:

Healthcare System-Emergency Room, MD., the claimant slipped on a wet floor injuring her left elbow and left hip bone. Assessment-Plan: Missing Information.

X-ray of the lumbar spine, pelvis and left elbow performed by, MD., showed no bony injuries are identified. Straightening of the lumbar spine suggestive of paraspinous muscle spasms.

Chiropractic Therapy from 9-6-02 through 9-26-02 (6 visits)

1-3-03 MRI of the lumbar spine without contrast performed by MD., showed L4-L5 has minimal disc bulge and facet hypertrophy but without neural foraminal stenosis. L5-S1 has disc bulge without neural foraminal stenosis. No focal component to suggest disc herniation at any level.

Physical Therapy from 2-6-03 through 2-20-03 (7 visits)

Physical Therapy from 3-20-03 through 5-20-03 (16 visits)

5-20-03 DO., performed a Medical Review. It was his opinion that he believes that the current complaints are related to the original injury. The evaluator cannot certify that all of the treatments prescribed thus far have been necessary. It appears to me that the amount of physical therapy dispensed has exceeded what should be required. It would be difficult to justify more than eight weeks of physical therapy. At that point in time, therapy would provide no specific benefit over a home exercise program. Diagnostics appeared reasonable. The records were very vague as to what medications had been specifically prescribed. It would not have been unusual however, for medications to have utilized. Most appropriately, a non-steroidal anti-inflammatory would have been of

benefit. Also, a short course of muscle relaxant for say one to two weeks would not have been inappropriate. At this time, additional interventions such as chiropractic care would not be reasonable or necessary and would provide no benefit for this individual. It appears, based on the documentation, that this claimant's primary problem at this point is an S1 joint dysfunction. This certainly could have occurred from this mechanism of injury. The evaluator believes that the most prudent course at this point would be to proceed with an S1 joint injection, which could be diagnostic, as well as therapeutic. The claimant should also have been taught at some time S1 joint stabilization exercises. Other than the injection for diagnostic and potentially therapeutic reasons, additional diagnostics would not be necessary. The use of a non-steroidal anti-inflammatory would not be considered inappropriate. This is about the only medication however, that would be indicated. The individual can definitely be returned to work. It is noted that she most recently has been at a restriction of no lifting over 10 pounds. As an occupational medicine physician, the evaluator would consider this an unrealistic restriction. The evaluator would consider this as over restricting the claimant. With an S1 joint dysfunction, the claimant should be able to lift considerably greater weight without any specific impact on her condition. The evaluator believes that an appropriate restriction would be somewhere in the realm of 25 pounds. It does not appear that MMI has yet been reached. She still appears to have a symptomatic S1 joint, which in all probability is not going to resolve with additional physical therapy, chiropractic treatment, etc. The claimant needs to be active in stabilization exercises and the evaluator suggests proceeding with an S1 joint injection. If she has the expected response, then MMI most likely will be reached within a few weeks. The evaluator would expect little to no impairment at that time.

9-17-03 MD., preoperative and postoperative diagnosis: Chronic intractable low back pain with radiculopathy. Procedure: Lumbar epidural injection of contrast, local anesthetic, steroids at L4-5 under fluoroscopy.

10-13-03 MD., performed a Required Medical Evaluation. It was her opinion that the current treatment has been reasonable and necessary and is causally related to the compensable injury. The evaluator thinks that she should try EMGs and nerve conduction studies. If these fail to show a lumbar radiculopathy, the evaluator would suggest work hardening. If these show a lumbar radiculopathy, the evaluator would suggest lumbar epidural steroid injections times three, and if there is no improvement, she might be a surgical candidate.

10-17-03 MD., performed an Independent Medical Evaluation. It was his opinion that the claimant has persistent left sciatica, and she apparently has a direct contusion of the sciatic nerve. The evaluator does not find evidence of a sacroiliac joint problem. She gets relief from taking Mobic and occasional Skelaxin, which is reasonable. She had a significant contusion or a sensory neuropraxia of the sciatic nerve, and this could take up to two years from the date of injury to resolve. Therefore, she is not at maximum medical improvement (MMI). The evaluator does not think that therapy is indicated.

The evaluator thinks that she should be managed with Mobic medication over the next six months to a year along with Skelaxin intermittently, and it should resolve. She should follow-up with her doctor every three months, and the evaluator feels that she would be at MMI within two years from the date of her injury. At this point in time, she does have a sensory abnormality, with radiation of the first circle nerve root, or the direct sensory component of the sciatic nerve. She is working. She does have some numbness, but it is forgotten with certain activities.

11-4-03 MD., (Illegible hand written notes). DWC-73: The claimant was returned to work from 11-4-03 through 12-4-03 with restrictions. Diagnosis: Lumbar back pain, left leg, left foot numbness.

12-11-03 MD., (Illegible hand written notes). DWC-73: The claimant was returned to work from 12-11-03 with restrictions. Diagnosis: Lumbar back pain, left leg, left foot numbness.

2-15-05 MD., the claimant complains of left sided hip pain radiating down her leg. The claimant slipped and fell on the floor and both feet came over her head. She landed on the left side on her head. This happened in xx/xx. She has had injections and has had improvements in her symptoms. The pain is mainly in the posterior aspect of her thighs radiating down through it. There is tingling in her foot that is becoming a constant problem. Physical Examination: She is able to walk on toes and heels. The strength in her lower extremities is 5-5. Reflexes are normal. Examination of mental status and cranial nerves reveal them to be normal. CT-myelogram of the lumbar spine dated 1-22-04 which does not reveal any canal or foraminal stenosis. There is an MRI of the lumbar spine dated 1-3-03. This also does not show any impingement on the nerve roots. Impression: Left sided S1 radiculopathy after a fall and landing on her left hip. Plan: The evaluator would like to review her EMG results. The evaluator thinks also this problem is mainly the compression other S1 nerve root outside her spine. The evaluator would like to get a pelvic MRI to further investigate this. The evaluator will follow-up with her, after these studies are completed.

3-10-05 MRI of the pelvis and left hip performed by MD., showed no evidence of fracture, destructive lesion, erosions, or avascular necrosis of the hips. No evidence of large effusion. No evidence of any pelvic fracture. The S1 joints are normal. Facet arthropathy, greater at L4-5. Normal appearing uterus and no large cystic adnexal masses.

3-18-05 MD., the claimant has had her MRI scan of her pelvic spine. MRI of the pelvis does not show any evidence of neural compression outside the spine. Impression: Left sided S1 radiculopathy after trauma. The evaluator cannot find any lesion to decompress to help her. The evaluator would like to refer her to Dr. for further evaluation of her S1 radiculopathy to see if there is anything he has to offer.

4-5-05 MD., the claimant referred to the office for evaluation of left leg pain. According to the claimant, approximately two years ago she slipped and fell, landing on her left buttock. Since then she has had pain in the left lower limb. She says it begins in the buttock and radiates down the posterior aspect of the thigh and leg to the foot. She describes the symptoms as dysesthetic and anesthetic in nature. She says the symptoms are constant, worsened by activity and Valsalva. She denies any significant weakness, denies any complaints in the right leg. To date, the claimant has trialed epidural steroid injections, one of which was helpful, as well as numerous over-the-counter medications which were not helpful. She has also tried hydrocodone, which takes the edge off, but has otherwise been marginally effective. Physical Examination: Neurologic exam: As on reverse, reveals mild diffuse hyperreflexia, as well as a mildly antalgic gait. Straight-leg raising sign was present on the left at 70 degrees, with pain reproduced in the foot. Impression: Lumbar radiculopathy. Plan: Will repeat EMG-nerve conduction studies. For symptomatic therapy, the claimant was prescribed Neurontin. The evaluator advised the claimant against any heavy lifting.

5-23-05 MD., the claimant returns for follow-up. Since her last visit, the claimant's symptoms have worsened. The Topamax have helped somewhat, but incompletely. MRI of the lumbosacral spine done today (reviewed) revealed left annular disc bulge with superimposed lateral disc protrusion, L5-S1, combining with mild facet arthrosis to produce some neural foraminal stenosis on the left contacting the left L5 nerve root. Impression: Lumbar radiculopathy. Plan: The claimant will continue Topamax, the evaluator gave her samples. The evaluator will refer the claimant back to Dr. for a surgical opinion in light of the new MRI findings.

5-23-05 MRI of the lumbar spine performed by MD., showed mild annular disc bulge with a superimposed left posterior lateral disc protrusion at L5-S1 combines with mild facet arthrosis to produce mild to moderate left foraminal stenosis, and mild right foraminal stenosis. The exiting left L5 nerve is contacted in the neural foramen. Mild to moderate facet arthrosis L4-L5.

6-16-05 MD., the claimant returns after her visit with Dr. Dr. had obtained a repeat MRI on her. The claimant's EMG was essentially normal. There was no evidence of nerve damage at this point. The evaluator actually went to Dr. office and reviewed the MRI with him. There is evidence of mild disc bulge at L5-S1 and also facet hypertrophy. This is not clear cut. To clarify the issue the evaluator would like to get a CT-myelogram of lumbar spine and the evaluator will see her back at that point.

7-11-05 MD., performed a Treating Doctor Evaluation. He certified the claimant has reached MMI on 7-11-05 with no impairment rating. DWC-73: The claimant was returned to work from 7-11-05 without restrictions.

10-15-05 MD., (Illegible hand written notes). DWC-73: The claimant was returned to work from 10-15-05 without restrictions. Diagnosis: Lumbar back pain, left leg, left foot numbness.

12-2-05 MD., performed a Medical Review. It was his opinion that he believes that the claimant has had a direct contusion to the sciatic nerve. There is certainly the possibility of a piriformis syndrome. The evaluator does not find primary back pathology. The evaluator is going to ask her to repeat her EMG-nerve conduction studies once more, and would like to evaluate that. The evaluator believes she is a candidate for exploration of the sciatic nerve of her buttock. The evaluator believes that she probably has some degree of piriformis syndrome. In the evaluator's opinion, her current condition is due to the work injury. The evaluator can better address treatment issues, once the evaluator has the results of the EMG.

1-20-06 MD., performed a Medical Review. It was his opinion that the electro diagnostic study was performed by Dr.. Her symptoms were suggestive of a left L5 pseudo-radiculopathy. He states that today's study is basically normal, but a prior study did show some evidence of remote L5 radiculopathy. In this case, due to the claimant's continuing symptoms, the evaluator does feel she needs an exploration procedure. The evaluator's opinion has basically not changed.

6-26-06 MD., (Illegible hand written notes). DWC-73: The claimant was returned to work from 6-26-06 without restrictions. Diagnosis: Lumbar back pain, left foot numbness.

12-22-06 MD., the claimant apparently works for the. Apparently, on xx/xx/xx, she injured herself when she fell on a recently cleaned oily floor slipping forward landing mostly on her left side. As a part of the investigation, the claimant has had a MRI of the back showing some age related degenerative changes but nothing of great significance. She has been taken care of by MD. It was suspected that the claimant might have sciatica. As a part of treatment, the claimant has had physical therapy. She has had epidural steroid injections into the hip and buttock region. She has also had different medications. Still as a part of the investigation, the evaluator have at least seen the claimant on one earlier occasion where EMG-NCV was performed by the evaluator on the claimant on 11-24-03 showing evidence of a very subtle and remote left L5 radiculopathy. The claimant returns today stating that she continues to do responsibilities for. The claimant states that she still has pain in the hip and buttock region but not in the back. It radiates down the lateral portion of the left lower extremity. Physical Examination: Cranial nerves appeared to be normal, Motor strength even for the left lower extremity was normal with normal bulk and tone. Sensation to pinprick was intact except for a hint decreased in the left L5 dermatomes, Reflexes were symmetrically normal even at the knees and ankles. Coordination and gait were normal. Nerve conduction study of the left lower extremity and EMG needle testing of the left lower extremity is normal. Impression: Symptoms suggestive of a left L5

pseudo-radiculopathy. On the evaluator's last study, he did show some evidence of minimal to remote left L5 radiculopathy. The evaluator does stand by those studies. On this particular test today, it is much more difficult to see and actually, it would be in order to call today's study normal showing no evidence of any neurological deficits. Plan: The claimant will return back to Dr.. She can return to see the evaluator on an as needed basis.

9-21-07., MD., preoperative and postoperative diagnosis: Chronic intractable low back pain with radiculopathy. Procedure: Lumbar epidural injection of contrast, local anesthetic, steroids at L5-S1 under fluoroscopy.

5-3-08 MD., preoperative and postoperative diagnosis: Chronic intractable low back pain with radiculopathy. Procedure: Lumbar epidural injection of contrast, local anesthetic, steroids at L5-S1 under fluoroscopy.

10-24-08, MD., preoperative and postoperative diagnosis: Chronic intractable low back pain with radiculopathy. Procedure: Lumbar epidural injection of contrast, local anesthetic, steroids at L5-S1 under fluoroscopy.

11-18-08 MD., the claimant's pain diagram is anatomic with pain starting in the left buttock, and radiating down the outer aspect of the left calf. She has pins-and-needles on the outer aspect of the left foot. Her pain is moderate-extreme, 7.5-9-10, increasing when she walks. She is using hydrocodone as needed for the pain, The claimant has low back pain and buttock pain all-time, with leg pain most of the time. Her leg pain is more significant than her back pain. She has numbness and weakness all of the time, and it is extremely bothersome. Coughing increases her pain. Sitting is relatively pain-free, but straightening up hurts her leg. Lying on her side does not alleviate her symptoms significantly. AP, lateral, flexion-extension x-rays of the lumbar spine were obtained today. Alignment is normal. There is no evidence of spondylosis or spondylolisthesis. Disk space height is decreased at L5-S1. No other degenerative changes are seen. All pedicles are visualized. All spinous processes are midline. Visualized soft tissues and bowl of the pelvis are normal. Psoas shadow is normal. Sacroiliac joints are normal. There is no pathologic motion between flexion and extension. Lumbar MRI on 4-11-08 shows L5-S1 combine disc bulge and facet hypertrophy, resulting in mild to moderate left neuroforaminal stenosis, without central stenosis. L4-5 demonstrates degenerative changes without neurologic compression. Diagnosis: Disc herniation, lumbar. Plan: The claimant has ongoing radiculopathy since the time of the injury. She has been receiving ongoing care, including epidural injection the since the time of the injury. The pain has continued to get worse, to the point where she does not wish to tolerate it any longer. Her symptoms are consistent with the imaging findings, and have been relieved by injections in the past. The claimant meets the ODG criteria for laminectomy and discectomy. The claimant understands that there is no guarantee that the symptoms will be cured by surgery and that there is a possibility they could be worse after the surgery.

12-17-08 MD., procedure performed: Lumbar laminectomy with decompression of the nerve roots, including discectomy and foraminotomy, left L5-S1. Use of the surgical microscope.

2-2-09 R. MD., the claimant states has very little numbness left in her foot, and mild pain in her buttock and flanks. She thinks that it's secondary to her having limped for so long. Current medications: Zanax, Omeprazole, Hydrocodone and B-12. Assessment: Surgical aftercare, unspecified. Plan: The claimant is going to continue with her activities. She is involved in a walking program. There are no restrictions at this time. If she still has back pain when the evaluator sees her in four weeks, he will start her in physical therapy. The claimant has been urged to call the office with any comments or concerns prior to the next visit.

3-17-09 MD., the claimant complains of low back pain with left radicular symptoms. Current medication: Lortab. Impression: Lumbar radiculopathy and low back pain. Plan: Continue current medication and follow-up in 6 months.

11-13-09 MD., performed a Medical Review. It was his opinion that the claimant had a specific date of injury related to a fall, has had ongoing treatment and symptoms since that point in time with surgery having been done in 12-08. There is no indication or any related preexisting conditions or injury that was aggravated by the work injury in the records reviewed. The treatment identified of office visits, diagnostic tests, referrals, medications, procedures and surgery follow evidenced based treatment guidelines or the treatment guidelines that were in effect at the time treatment was rendered. The current evidenced based treatment plan based on criteria within the Official Disability Guidelines would indicate office visits with her pain management doctor, Dr. would be at approximately every six months to monitor her use of medications and for any periodic need to have an invasive injection such as an epidural steroid injection. In relationship to follow-up visits with her surgeon, Dr., follow-up over the next couple of years at every six months to follow the status of the post surgical condition. Current medications as related to the work injury of Lortab or equivalent are reasonable and necessary as relating to the Official Disability Guidelines which would indicate with the use of medications she is able to maintain an active full time work schedule. At this point in time there is no specific indication of a need for diagnostic testing, additional surgery, DME, or supervised physical therapy as she would be anticipated to be on a home exercise program. The claimant is currently working at a full time capacity.

1-25-10 MD., performed an Independent Medical Evaluation. It was his opinion that the claimant is status post a lumbar laminectomy and discectomy in 12-08. However, her injury was in xxxx, and she had ongoing pain since that point in time. Her medical care has been reasonable and necessary. She is taking one to two Hydrocodone per day, and she takes Xanax to help her at night. The evaluator feels those medications are indicated. Usually, with back surgery following an acute injury,

these medications are used short-term. However, this claimant has had ongoing problems since xxxx, and she will have some degree of remaining chronic pain. She is entirely cognitive. She is not dysarthric. She does not have any ataxia. She is continuing to work. So, one to two hydrocodone a day and a 0.25 Xanax at night to help her sleep, the evaluator feels it would be indicated. These medications will probably be needed for the remainder of her life.

On 12-21-10, MD., reports that the claimant has low back pain with left radicular symptoms. The evaluator recommended medial branch blocks. The claimant is continued on her same medications Xanax. The claimant is to follow up in six months.

12-27-10 MD., performed a Utilization Review. He reported that it is the opinion of the reviewing physician that, "Request is for facet joint Injections levels unspecified. Last office visit shows patient has intractable low back pain. Still has back pain worse with extension, no radicular component, worse with activity. Chief complaint is low back pain with left radicular symptoms, Office visit of 11/18 shows claimant was no tenderness in the para lumbar area. There is decrease sensation on the lower aspect of the foot of the S1 distribution. Request does not meet criteria in that there is no tenderness over the facet regions and there is a question of radiculopathy. Also the levels are not specified. Therefore at this time and on this information request is not approved.

1-18-11 MD., performed a Utilization Review. It is the opinion of the reviewing physician that, the claimant was injured in xxxx when she slipped on a wet floor. The previous request was denied for several reasons. The level of injections was not given. There was no evidence of tenderness over the facet. There was a question of radiculopathy. The evaluator reviewed the material submitted. The claimant slipped on a wet floor and fell. At the time of injury the claimant had no evidence of facet hypertrophy on MRI (up until 2004). Her symptoms consisted of low back pain with left leg pain. Epidural steroid injections (ESI) gave short-term relief. She was followed until 11/08 by Dr. and Dr.. On 11/18/08 she stated that she had leg pain all of the time (left). Straight leg raising was normal. Decreased sensation was noted laterally in the S1 distribution. There is a note from Center for Pain Management (dated 12/21/10) that states the claimant had medial branch blocks on 10/24/08 (level not given). This gave her 80% relief for an unknown time duration. There is no record of any follow-up for the next two years until 12/21/10. This note states she had surgery (She cannot find when this occurred). Her primary complaint as now of low back pain.

The evaluator was unable to authorize this procedure based on the information provided. There is no indication of the level of the surgical procedure that apparently occurred. There is no documentation of what happened from 2008 to 2010 except for the one note of medial branch blocks (at an unknown level for unknown duration of pain relief). The claimant does not appear to undergo a home exercise program. There is no evidence of physical therapy. She is not on a NSAID. There is minimal evidence of underlying medical problems except that she has pernicious anemia. A weight was not given. There was no evidence on clinical exam on 12/21/10 to support this procedure.

This request is in complete contraindication to the ODG as noted by the previous reviewer and is non-authorized.

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

BASED ON THE RECORDS PROVIDED, THE CLAIMANT HAS BEEN HAVING RADICULOPATHY ALL ALONG AND NOT LOCALIZED PARAVERTEBRAL PAIN TO JUSTIFY THE MEDIAL BRANCH BLOCKS. PER CURRENT EVIDENCE BASED MEDICINE, MEDIAL BRANCH BLOCKS ARE NOT RECOMMENDED IN CLAIMANT'S WITH RADICULAR PAIN. THEREFORE, THE REQUEST FOR OUTPATIENT MEDIAL BRANCH BLOCKS IS NOT REASONABLE OR MEDICALLY INDICATED.

ODG-TWC, last update 2-17-11 Occupational Disorders of the Low Back – Facet joint medial branch blocks: Not recommended except as a diagnostic tool. Minimal evidence for treatment.

Pain Physician 2005: In 2005 *Pain Physician* 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. (Boswell, 2005) This was supported by one study. (Manchikanti, 2001) 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 (8.4 ± 0.31 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 *Pain Physician*.] The average relief per procedure was 11.9 ± 3.7 weeks.

Pain Physician 2007: This review included an additional randomized controlled trial. (Manchikanti2, 2007) 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. (Boswell2, 2007) 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. (Wasan, 2009) The use of the blocks for diagnostic purposes is discussed in Facet joint diagnostic blocks (injections). See also Facet joint intra-articular injections (therapeutic blocks).

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)