



7331 Carta Valley Drive | Dallas, Texas 75248 | Phone: 214 732 9359

Notice of Independent Review Decision

**DATE OF REVIEW:** 5/14/2011

**IRO CASE #:**

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

L5/S1 Facet Injection 72275 62311 62282 77003 72114

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

DO whose Specialty is Anesthesiology and Pain Medicine

**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**





**PATIENT CLINICAL HISTORY [SUMMARY]:**

Mr., a male, was initially injured on xx/xx/xx. Patient has been treated for low back pain radiating down the left leg and the left foot. As per Dr., physical exam showed mild tenderness @ L4-5 region, decreased sensation in the left L-5 nerve root distribution, motor function demonstrates 4/5 weakness in the left extensor hallucis longis muscle, no muscle atrophy was appreciated. Dr.'s impression was L5-S1 herniated disc and left L5 Radiculopathy. MRI dated 2/28/2011 showed mild facet and ligamentum flavum hypertrophy @ L4-5 as well as minimal predominantly anterior sided degenerative disc disease; however, there is no significant spinal canal or neuroforaminal narrowing. At L5-S1 level, there is a mild bilateral facet and ligamentum flavum Hypertrophy, as well as moderate to marked predominantly anterior sided disc osteophyte complex, left side greater than right resulting in mild grade 1 retrolithesis of L5-S1. Also, lateral recess narrowing bilaterally with minimal abutment of both traversing S1 nerve roots and bilateral neural foraminal narrowing with abutment of both exiting L5 nerve roots. There is no significant spinal canal narrowing.

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

Decision: After reviewing the MRIs, medical history and medical exams, L5-S1 facet injection is considered not medically necessary based on ODG guidelines.

The ODG treatment guidelines Low Back chapter recommends facet injections based on the following criteria.

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.

The patient is exhibiting low back pain with left L5 radiculopathy. Based on the presence of radicular findings, L5-S1 facet injection is non-certifiable per ODG guidelines

## **REFERENCES**

ODG treatment guidelines:

- Low back chapter
- Facet injections
- Facet joint injections, lumbar
- Facet joint injections, thoracic

### **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)]

Facet joint injections, lumbar:

[Facet joint injections, multiple series](#); [Facet joint diagnostic blocks](#) (injections); [Facet joint intra-articular injections](#) (therapeutic blocks); [Facet joint medial branch blocks](#) (therapeutic injections); [Facet joint pain, signs & symptoms](#); & [Facet joint radiofrequency neurotomy](#). Also [Neck Chapter](#) and [Pain Chapter](#).

### **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



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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 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 CRITERI
- 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)