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### **Notice of Independent Review Decision**

**DATE OF REVIEW:** 10-19-2011

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of lumbar facet joint injection at the bilateral L5-S1 under flourosopic guidance with conscious sedation.

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

The reviewer is a Medical Doctor who is board certified in Anesthesiology. This reviewer has been practicing for greater than 10 years.

**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)

The reviewer agrees with the previous adverse determination regarding the lumbar facet joint injection at the bilateral L5-S1 under flourosopic guidance with conscious sedation.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male employee who sustained an injury when he fell 10 feet and injured his back, left ankle, knee and waist. At the time of injury, the patient was diagnosed with back pain, ankle sprain, left knee pain and talus fracture. He is status post left knee arthroscopy with partial meniscectomy abrasion chondroplasty lateral tibial articular surface defect and application of platelet gel on 08/20/2010. He has reached maximum medical improvement on 11/20/2010 with 15% impairment rating. MRI of the lumbar spine dated 05/13/2010 revealed early degenerative disc disease involving L5-S1 disc space, central and right-sided disc protrusion at the L5-S1 level, left lateral recess disc protrusion at the L2-L3 level, and

degenerative spondylolisthesis of L6 vertebral body with reference to S1 with moderate facet arthropathy.

As per the medical report dated 05/18/2011, the patient complained of low back pain and pain in both legs. He rated pain as 9 out of 10 in a pain scale. He stated that his pain is worse at night. He stated that his legs do tire if he walks too far. He has had epidural steroid injection. On examination, tenderness is noted at the region of L4-L5 and L5-S1. He has pain with flexion and extension. He has had physical therapy, surgery and a chronic pain management program. As per the RME report dated 06/02/2011, which states that the patient has reached maximum medical improvement at the end of 11/2010 and has 15% whole person impairment rating. The current request is for a lumbar facet joint injection at the bilateral L5-S1 under fluoroscopic guidance with conscious sedation. The records show that the patient has previously undergone ESI's. Lumbar spine X-ray shows disc space narrowing at L5-S1. There is a slight listhesis of L5 on S1. The disc levels above appear relatively normal except for some mild osteophytic changes. A lumbar spine MRI shows early degenerative disc disease involving L5-S1 disc space, central and right-sided disc protrusion

at the L5-S1 level, left lateral recess disc protrusion at the L2-3 level, and degenerative spondylolisthesis of L5 vertebral body with reference to S1 with moderate facet arthropathy.

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

The requested service is not recommended. This is an appeal for a bilateral L5-S1 facet joint injection with fluoroscopy and sedation. The patient is a xx-year-old male who sustained an injury last xx/xx/xx. The patient experiences back pain. The records submitted for review did not contain an adequate clinical assessment from a treating physician with subjective and objective findings that substantiate the necessity of the requested service. Furthermore, there was no adequate objective documentation of the failure and outcomes of conservative treatment and pharmacotherapy. Moreover, objective evidence of extreme anxiety to substantiate the necessity of performing the requested procedure with sedation was not provided for review, as per referenced guidelines. As such, the previous non-certification of the medical necessity for this request for a bilateral L5-S1 facet joint injection with fluoroscopy and sedation is upheld.

Basis for Decision:

Criteria used in analysis:

Official Disability Guidelines-Treatment for Workers' Compensation, Online Edition

Chapter: Low Back - Lumbar and Thoracic

Facet joint medial branch blocks (therapeutic injections)

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 ( $8.4 \pm 0.31$  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  $11.9 \pm 3.7$  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.

#### Facet joint diagnostic blocks (injections)

Recommend no more than one set of medial branch diagnostic blocks prior to facet neurotomy, if neurotomy is chosen as an option for treatment (a procedure that is still considered "under study"). Diagnostic blocks may be performed with the anticipation that if successful, treatment may proceed to facet neurotomy at the diagnosed levels. Current research indicates that a minimum of one diagnostic block be performed prior to a neurotomy, and that this be a medial branch block (MBB).

#### 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 <sup>3</sup> 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.

Facet joint pain, signs & symptoms

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.

**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)