

Independent Reviewers of Texas
4100 West Eldorado Pkwy #100-373
McKinney TX 75070
independentreviewers@hotmail.com
Phone: 469-218-1010
Fax#: 469-374-5862

Notice of Independent Review Decision

DATE OF REVIEW: 02/13/12

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Facet Injections L4-5, L5-S1

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

Texas Board Certified Orthopaedic Surgeon

REVIEW OUTCOME

Upon independent review, the reviewer finds that the previous adverse determination/adverse determination should be:

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Clinical notes dated 09/23/2011 through 01/18/2012 by Dr. MRI of the lumbar spine without contrast by Dr. dated for 01/04/2012, MRI of the lumbar spine without contrast by Dr. dated for 01/12/2011, x-ray of the lumbar spine for reviews by Dr. dated for 09/26/2011, and prior reviews dated for 11/28/2011 and 12/19/2011.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient is a who has complaints of back and leg pain. According to clinical note dated xx/xx/xx reports that the patient has ongoing back and leg symptoms. The patient reports 75% of low back pain and 25% of bilateral leg pain with numbness and tingling. The patient states that his pain radiates down the lateral thigh and lateral shin, as well as the posterior thigh and calf area. The patient states that his symptoms are worse with sitting, standing, and walking. The note reports that the patient has had acupuncture as well as epidural steroid injections. The note reports that the first 2 injections gave him 2 days of relief; the patient had a subsequent 3rd injection which gave him 3 days of 75% improvement. Physical examination of the lumbar spine revealed tenderness to palpation in the paraspinous regions bilaterally. The

patient had a positive straight leg raise and Lasègue test bilaterally. The patient had absent patellar and Achilles reflexes bilaterally. Sensory to light touch was decreased in the dorsum of the foot and lateral foot bilaterally. The patient had intact sensory to light touch and the remainder of the lower extremities. The patient had 5/5 hip flexion, leg extension, leg flexion, tibialis anterior and EHL strength bilaterally. The patient had 4+/5 gastric soleus weakness.

According to x-ray of the lumbar spine dated for 09/26/2011 reports that there is no acute abnormality of the lumbar spine, mild dextroscoliosis of the lumbar spine, and degenerative changes of the lumbar spine were noted.

MRI of the lumbar spine dated for 01/04/2012 reports that at levels L4-5 there was mild spondylosis, disc desiccation with diffuse bulging of the annulus without significant lateralization. There was shallow superimposed broad-based posterior central disc extrusion with slight inferior migration of herniated disc material. Mild to moderate facet arthropathy was noted. Ventrally indented thecal sac was adequate. Mild to moderate left and mild neural foraminal stenosis was noted. L5-S1 revealed mild spondylosis, small Schmorl's node along the right inferior endplate of L5; shallow diffuse bulging of the annulus was noted. There was suggestion of a shallow superimposed disc protrusion at the left posterior margin of the disc, encroaching on the left subarticular recess, possibly impinging on the left L5 nerve root at the orifice of the left neural foramen. Moderate to severe left and moderate right neural foraminal stenosis was noted. Mild/moderate facet arthropathy was noted.

MRI of the lumbar spine dated for 01/12/2011 reports that there was a 3-4 mm left paracentral discal substance protrusions/herniations that minimally indented the thecal sac, however, 4-5 mm of the inferior substance extrusions were associated at levels L3-4 and L4-5. At levels L5-S1, there was a 2-3 mm left paracentral discal substance protrusion/herniation that minimally indents on the thecal sac.

Clinical note dated 01/18/2012 reports that the patient was seen for a follow up of low back and leg symptoms. The patient reported tingling and numbness type feeling in his legs but no significant radiating pain. The patient states that his pain was an 8/10 to 9/10. The patient had a positive and direct straight leg raise bilaterally. Sensory exam was slightly decreased in the dorsum of the lateral aspect of both feet.

Prior reviews dated 11/28/2011 denied the facet injections at levels L4-5 and L5-S1. Given that the patient had radicular symptoms and that there was documentation of previous treatment of pain management program. Prior review dated for 12/19/2011 denied the facet injections at levels L4-5 and L5-S1 given that there was findings of radiculopathy.

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

The patient who has complaints of back and leg symptoms was reported to have some tingling and numbness type feelings in his leg. The patient was reported to have a positive direct straight leg raise bilaterally. The patient was reported to have slightly decreased sensory. This reviewer agrees with the previous reviews dated for 11/28/2011 and 12/19/2011, given that there are clear findings of radiculopathy upon physical examination. **Official Disability Guidelines** indicate facet injections should be limited to patients with low back pain that is nonradicular in nature. Given that the patient had a positive straight leg raise and Lasègue's bilaterally, the patient had decreased reflexes, and decreased sensation along with an MRI that

revealed disc herniations at levels L3-4 and L4-5 and L5-S1, the request for facet injections at L4-5 and L5-S1 is non-certified.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

Official Disability Guidelines, Low Back Chapter, Online Edition

Criteria for the use of diagnostic blocks for facet nerve 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 cervical 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 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, with recent literature suggesting a volume of 0.25 cc to improve diagnostic accuracy.
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 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.
11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level.
12. It is currently not recommended to perform facet blocks on the same day of treatment as epidural steroid injections or stellate ganglion blocks or sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment.