

CASEREVIEW

8017 Sitka Street
Fort Worth, TX 76137
Phone: 817-226-6328
Fax: 817-612-6558

Notice of Independent Review Decision

DATE OF REVIEW: February 10, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Facet Injection L4/5 -62311(NJX C+-DX/THER SBST EDRL/SARACH LMBR SAC),
64493 (NJX DX/THER AGT PVRT FACET JT LMBR/SAC 1 LEVEL), 77003 (FLUOR
GID & LOCLZJ NDL/CATH SPI DX/THER NJX)

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

This physician is Board Certified by American Board of Orthopedic Surgeons 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)

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:

06/02/10: Office Visit at Orthopaedic Center with MD
06/14/10: Office Visit at Orthopaedic Center with MD
06/21/10: MRI Thoracic Spine without contrast interpreted by MD

06/28/10: Office Visit at Orthopaedic Center with MD
07/08/10: Office Visit at Orthopaedic Center with MD
07/08/10: Texas Outpatient Non-Authorization Recommendation from for Thoracic ESI T3/4, T4/5, T5/6 w/IV sedation
07/22/10: Office Visit at Orthopaedic Center with MD
07/30/10: Operative Report by MD
08/05/10: Office Visit at Orthopaedic Center with MD
08/05/10: Transcription of MRI of the Lumbar Spine by MD
08/12/10: Office Visit at Orthopaedic Center with MD
09/08/10: Office Visit at Orthopaedic Center with MD
09/21/10: Outpatient Non-Authorization Recommendation from for Thoracic ESI T3/4 and T4/5
10/12/10: Operative Report by MD
10/21/10: Office Visit at Orthopaedic Center with MD
11/04/10: Workers' Compensation Clinic Note by MD
11/09/10: Physical Therapy Evaluation at Orthopaedic Center by LPT
11/18/10: Office Visit at Orthopaedic Center with MD
12/10/10: Office Visit at Orthopaedic Center with MD
01/07/11: Office Visit at Orthopaedic Center with MD
01/13/11: Report of Medical Evaluation by, MD
01/28/11: Office Visit at Orthopaedic Center with MD
02/04/11: Office Visit at Orthopaedic Center with MD
02/17/11: Fluoroscopic Guided thoracic Myelogram interpreted by MD
02/17/11: CT Scan of the Thoracic Spine w/o contrast interpreted by, MD
03/02/11: Office Visit at Orthopaedic Center with MD
03/09/11: Office Visit at Orthopaedic Center with MD
03/18/11: Office Visit at Orthopaedic Center with MD
04/06/11: Office Visit at Orthopaedic Center with MD
05/04/11: Office Visit at Orthopaedic Center with MD
06/16/11: Preop Screening by MD
06/28/11: Operative Report by MD
07/18/11: Office Visit at Orthopaedic Center with MD
08/16/11: Physical Therapy Evaluation at Orthopaedic Center by
08/29/11, 09/08/11, 09/15/11, 09/21/11, 09/22/11, 09/29/11, 10/07/11, 10/11/11: Physical Therapy Daily Notes from Orthopaedic Center
09/07/11: Office Visit at Orthopaedic Center with MD
09/09/11: Office Visit at Orthopaedic Center with MD
10/07/11: Office Visit at Orthopaedic Center with MD
10/19/11: Functional Capacity Evaluation performed at Orthopaedic Center by PT
11/04/11: Office Visit at Orthopaedic Center with MD
11/11/11, 11/25/11, 12/09/11, 12/16/11: Work Hardening Program Progress Notes from Functional Restoration Services
12/02/11: Office Visit at Orthopaedic Center with, MD
12/14/11: Office Visit at Orthopaedic Center with, MD
12/19/11: UR performed by, MD
12/28/11: UR performed by MD

01/06/12: Office Visit at Orthopaedic Center with MD

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who was injured when she was lifting a bag on xx/xx/xx and injured her upper back. Treatment has included physical therapy, Ibuprofen, Skelaxin, Ultracet, Voltaren, Lortab, Naprosyn, Levaquin, Xanax, Norco, Opana ER, Cymbalta, Robaxin, Ambien, thoracic ESIs, left thoracic trigger point injections, thoracic laminectomy, and work hardening.

On June 2, 2010, the claimant was evaluated by MD who diagnosed back strain, thoracic. Continuation of physical therapy was recommended and she was prescribed Voltaren.

On June 21, 2010, MRI of the Thoracic Spine, Impression: Disk osteophyte complexes most pronounced from T3-4 through T5-6 levels with flattening/indentation on the thoracic cord and to a lesser degree at T1-2, T2-3, and T6-7 levels with no abnormal cord signal intensity seen.

On July 22, 2010, the claimant was evaluated by MD who reported she continued to have complaints of chronic sharp, aching, dull, throbbing pain in her thoracic spine. She also had complaints of pain in the lumbar spine with radiculopathy going toward the gluteal area and caudad that had been increasing in severity. Dr. added to her diagnosis lumbar pain and recommended an MRI of the lumbar spine.

On July 30, 2010, an Operative Report by MD. Postoperative diagnosis: Thoracic herniated disk, thoracic pain, thoracic radiculopathy. Procedure: Thoracic epidural steroid injection, T3-4, T4-5, T5-6 with epidurogram.

On August 5, 2010, Dr. transcribed the following for an MRI of the Lumbar Spine: Impression: Minimal abnormalities, as described. (L4-5 mild facet arthrosis bilaterally. Minimal bulge of the disc. Slight thickening of the yellow ligament. L5-S1 minimal/mild facet arthrosis bilaterally. Minimal bulging of the disc.)

On October 12, 2010, an Operative Report by MD. Postoperative diagnosis: Thoracic herniated disk. Procedure: Epidural steroid injection at T3-4 with the spread at T3-4 and T4-5 under fluoroscopy.

On December 10, 2010, the claimant was evaluated by MD for a pain management consultation regarding her chief complaint of back pain. Dr. diagnosed thoracic back pain, herniated thoracic disc w/o myelopathy, myofascial pain syndrome, and situational depression. Dr. increased her Cymbalta, changed Lortab to Norco, and prescribed a trial of Opana ER 5 mg. Dr. also performed left thoracic trigger point injections.

On February 17, 2011, Myelogram/CT Scan Thoracic Spine, Impression: At T2-3 level, posterior disc bulge which is asymmetric to the right is seen. This results in effacement

of the right ventral thecal sac and mild cord deformity. At the T3-4 level, posterior disc bulge is seen resulting in mild cord deformity. At the T4-5 level, posterior disc bulge and osteophytosis is seen resulting in cord deformity. At the T5-6 level posterior disc bulge and osteophytosis is seen resulting in mild cord deformity. At the T6-7 and T7-8 levels, posterior disc bulge is seen resulting in mild effacement of the ventral thecal sac.

On June 28, 2011, Operative Report by MD. Postoperative diagnosis: Herniated nucleus pulposus, T4-5 and T5-6 on the left, with persistent upper back pain and radicular symptomatology. Procedure: Thoracic laminectomy with pediculectomy of T4-5 and T5-6 on the left.

On July 18, 2011, the claimant had a follow-up evaluation with Dr. who reported she was doing better 3 weeks postop.

On November 4, 2011, the claimant had a follow-up evaluation with Dr. who reported upper back pain was intermittent at level 5 without radiation in the arms. It was also noted that she started a work-hardening program. PE was limited to the cervical and thoracic spine.

On November 25, 2011, it was reported in a Work Hardening Program progress note that the claimant complained of intermittent increase in low back pain, which the claimant believed may have been due to increasing the resistance when performing strength training exercises.

On December 2, 2011, the claimant had a follow-up evaluation with Dr. for complaints of chronic sharp burning in her mid back without any leg pain. She also reported having left leg numbness and tingling after doing leg exercises in her work hardening and felt complete numbness in her heel. On physical examination station and gait were normal. There was no atrophy, spasticity or fasciculations. Motor strength of the lower extremities were a grade 5. Deep tendon reflexes were normoactive. Sensory examination was normal in the lower extremities. Alignment of the lumbar spine was normal. Range of motion of the lumbar spine was not limited. The sacroiliac joints were not painful. To palpation, there was no evidence of tenderness or spasm.

On December 14, 2011, the claimant had a follow-up evaluation with Dr. who noted that the claimant reported re-injuring her lower back while in Work Hardening on xx/xx/xx. She reported pushing 110 pounds on a leg press and felt a pinch in her lower back at that time. She had worsened and aching pain in her lower back with numbness in her left foot and pain that went to the gluteal and paraspinal areas in the left. On physical examination range of motion was limited in flexion, extension and lateral tilting. Sacroiliac joints were not painful. To palpation, there was evidence of tenderness and spasm. Straight leg raising reproduced radiculopathy that went to the left gluteal area. Diagnosis: Herniated Thoracic Disc w/o Myelopathy and Lumbar Pain. Dr. recommended LES l4-5 and facet injection in the left.

On December 19, 2011, MD performed a UR on the claimant. Rationale for Denial: In this case, ODG-TWC Low Back Procedure Summary last updated 11/30/11 identifies criteria for the use of diagnostic blocks for facet "mediated" pain. In this case, guidelines state that facet blocks are limited to patients whose pain is non-radicular. Guidelines also identify suggested indicators of pain related to facet joint pathology as tenderness to palpation in the paravertebral areas (over the facet region), a normal sensory examination, the absence of radicular findings and a normal straight leg raising exam. In this case, peer discussion indicates that the claimant has tenderness and spasm however location of specifics regarding facet joints is not submitted. In addition, the claimant is noted to have radicular pain and has a positive straight leg raise test upon examination. According to the criteria set out by guidelines, the requested procedure, facet injection L4/5, is not seen as medically reasonable and necessary in this case. Recommend non-certification.

On December 28, 2011, MD performed a UR on the claimant. Rationale for Denial: The claimant has complaints of pain with a re-injury to the back that was incurred on xx/xx/xx. The claimant has low back pain with numbness to the left foot and gluteal region. Pain radiates to the buttocks when walking. Objective exam notes tenderness and spasm and positive straight leg raise with symptoms to the left gluteal region. CT scan dated 06/28/11 notes that the levels affected are the T4-T5 and T5-T6. There are other lesions but these 2 are the more significant from the stand point of the largest pathology. The claimant has had conservative care including physical therapy. The claimant has had work hardening and it is noted that symptoms are not improved. Upon exam there is limited evidence of facet generated pain. Provider documents conflicting information regarding low back pain and lower extremity complaints. Straight leg raise is noted as positive without documentation of degree of motion and with radicular pain to the gluteus. There is no exam finding specific to facet generated pain. There has been no diagnostic workup and provider's plan is to inject the facet and perform an epidural steroid injection at the same time. There is no definition of the pain generator to support necessity of facet injections. Symptoms and exam findings are not consistent with facet generated pain at any specific level. Medical necessity of the request is not evident.

On January 6, 2012, the claimant had a follow-up evaluation with Dr. who noted the claimant mid back pain was at a constant level of 6/10 without radiation into the arms, but numbness in both arms, and low back pain constant at level 8 with radiation into the left leg. The claimant also complained of numbness and tingling in the left toes and left leg with weakness in the left leg. On physical examination range of motion was limited, sacroiliac joints were not painful, there was evidence of tenderness or spasm, and straight leg raising did not reproduce radiculopathy.

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

The previous adverse determinations are upheld. There are no obvious clinical findings that indicate the claimant's back problems are primarily facet arthropathy. There are no x-ray or MRI findings that show anything more than minimal to mild facet arthrosis. Her lumbar pain is more radicular in nature, although her clinical examinations are not consistent.

It was reported on the 12/14/11 physical examination by Dr. that with palpation, there was evidence of tenderness and spasm and straight leg raising reproduced radiculopathy that went to the left gluteal area. Based on ODG criteria, 'there should be no evidence of radicular pain', the request for Facet Injection L4/5 -62311, 64493, 77003 would not be medically necessary or recommended and is therefore denied.

ODG:

Facet joint intra-articular injections (therapeutic blocks)	<p>Under study. Current evidence is conflicting as to this procedure and at this time no more than one therapeutic intra-articular block is suggested. If successful (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). If a therapeutic facet joint block is undertaken, it is suggested that it be used in consort with other evidence based conservative care (activity, exercise, etc.) to facilitate functional improvement. (Dreyfuss, 2003) (Colorado, 2001) (Manchikanti, 2003) (Boswell, 2005) See Segmental rigidity (diagnosis). In spite of the overwhelming lack of evidence for the long-term effectiveness of intra-articular steroid facet joint injections, this remains a popular treatment modality. Intra-articular facet joint injections have been popularly utilized as a therapeutic procedure, but are not currently recommended as a treatment modality in most evidence-based reviews as their benefit remains controversial. The therapeutic facet joint injections described here are injections of a steroid (combined with an anesthetic agent) into the facet joint under fluoroscopic guidance to provide temporary pain relief. (Dreyfuss, 2003) (Nelemans-Cochrane, 2000) (Carette, 1991) (Nelemans, 2001) (Slipman, 2003) (van Tulder, 2006) (Colorado, 2001) (ICSI, 2004) (Bogduk, 2005) (Resnick, 2005) (Airaksinen, 2006) An updated Cochrane review of injection therapies (ESIs, facets, trigger points) for low back pain concluded that there is no strong evidence for or against the use of any type of injection therapy, but it cannot be ruled out that specific subgroups of patients may respond to a specific type of injection therapy. (Staal-Cochrane, 2009)</p> <p><i>Systematic reviews endorsing therapeutic intra-articular facet blocks:</i> <i>Pain Physician, 2005:</i> In 2005 there were two positive systematic reviews published in <i>Pain Physician</i> that stated that the evidence was moderate for short-term and limited for long-term improvement using this intervention. (Boswell, 2005) (Boswell, 2005) These results were based, in part, on five observational studies. These non-controlled studies were confounded by variables such as lack of confirmation of diagnosis by dual blocks and recording of subjective pain relief, or with measures that fell under verbal rating and/or pain relief labels (measures that have been reported to have problems with validity). (Edwards, 2005) <i>Pain Physician, 2007:</i> <i>Pain Physician</i> again published a systematic review on this subject in 2007 and added one additional randomized trial comparing intra-articular injections</p>
---	--

	<p>with sodium hyaluronate to blocks with triamcinolone acetonide. The diagnosis of facet osteoarthritis was made radiographically. (Fuchs, 2005) Two randomized trials were not included, in part, as they failed to include controlled diagnostic blocks. These latter articles were negative toward the use of therapeutic facet blocks. (Lilius, 1989) (Marks, 1992) An observational non-controlled study that had positive results was included that made the diagnosis of lumbar facet syndrome based on clinical assessment of “pseudoradicular” lumbar pain, including evidence of an increase of pain in the morning and with excessive stress and exercise (no diagnostic blocks were performed). (Schulte, 2006) With the inclusion of these two articles the conclusion was changed so that the evidence for lumbar intra-articular injections was “moderate” for both short-and long-term improvement of low back pain. (Boswell2, 2007)</p> <p><i>Complications:</i> These included suppression of the hypothalamic-pituitary-adrenal axis for up to 4 weeks due to steroids with resultant elevated glucose levels for less than a week. (Ward, 2002) There have been rare cases of infection (septic arthritis, epidural abscess and meningitis). (Cohen, 2007) Complications from needle placement include dural puncture, spinal cord trauma, intraarterial and intravenous injection, spinal anesthesia, neural trauma, pneumothorax, and hematoma formation. (Boswell2, 2007)</p> <p><i>Single photon emission computed tomography: (bone scintigraphy, SPECT scan):</i> Not recommended although recent research is promising. This technique is recommended based on the ability of radionuclide bone scintigraphy to detect areas of increased function, depicting synovial areas of inflammation as well as degenerative changes. Thirteen of 15 patients had a > 1 standard deviation pain score improvement at 1 month versus 7 of 32 patients with a negative or no scan. The benefit of the injection lasted for approximately 3 months and did not persist to 6 months. (Pneumaticos2, 2006) See also Facet joint diagnostic blocks (injections); Facet joint pain, signs & symptoms; Facet joint radiofrequency neurotomy; Facet joint medial branch blocks (therapeutic injections); & Segmental rigidity (diagnosis). Also see Neck Chapter and Pain Chapter.</p> <p>Criteria for use of therapeutic intra-articular and medial branch blocks, are as follows:</p> <ol style="list-style-type: none"> 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.
Facet joint pain, signs & symptoms	<p>Recommend diagnostic criteria below. Diagnostic blocks are required as there are no findings on history, physical or imaging studies that consistently aid in making this diagnosis. Controlled comparative blocks have been suggested due to the high false-positive rates (17% to 47% in the lumbar spine), but the use of this technique has not been shown to be cost-effective or to prevent a false-positive response to a facet neurotomy. (Bogduk, 2005) (Cohen 2007) (Bogduk, 2000) (Cohen2, 2007) (Manchukonda 2007) (Dreyfuss 2000) (Manchikanti 2003) The most commonly involved lumbar joints are L4-5 and L5-S1. (Dreyfus, 2003) In the lumbar region, the majority of patients have involvement in no more than two levels. (Manchikanti, 2004)</p> <p><i>Mechanism of injury:</i> The cause of this condition is largely unknown, but suggested etiologies have included microtrauma, degenerative changes, and inflammation of the synovial capsule. The overwhelming majority of cases are thought to be the result of repetitive strain and/or low-grade trauma accumulated over the course of a lifetime. Less frequently, acute trauma is thought to be the mechanism, resulting in tearing of the joint capsule or stretching beyond physiologic limits. Osteoarthritis of the facet joints is commonly found in association with degenerative joint disease. (Cohen 2007)</p> <p><i>Symptoms:</i> There is no reliable pain referral pattern, but it is suggested that pain from upper facet joints tends to extend to the flank, hip and upper lateral thighs, while the lower joint mediated pain tends to penetrate deeper into the thigh (generally lateral and</p>

posterior). Infrequently, pain may radiate into the lateral leg or even more rarely into the foot. In the presence of osteophytes, synovial cysts or facet hypertrophy, radiculopathy may also be present. (Cohen 2007) In 1998, Revel et al. suggested that the presence of the following were helpful in identifying patients with this condition: (1) age > 65; (2) pain relieved when supine; (3) no increase in pain with coughing, hyperextension, forward flexion, rising from flexion or extension/rotation. (Revel, 1998) Recent research has corroborated that pain on extension and/or rotation (facet loading) is a predictor of poor results from neurotomy. (Cohen2, 2007) The condition has been described as both acute and chronic. (Resnick, 2005)

Radiographic findings: There is no support in the literature for the routine use of imaging studies to diagnose lumbar facet mediated pain. Studies have been conflicting in regards to CT and/or MRI evidence of lumbar facet disease and response to diagnostic blocks or neurotomy. (Cohen 2007) Degenerative changes in facets identified by CT do not correlate with pain and are part of the natural degenerative process. (Kalichman, 2008) See also [Facet joint diagnostic blocks](#) (injections); & [Segmental rigidity](#) (diagnosis).

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.

Indictors 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)**