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Notice of Independent Review Decision

DATE: July 31, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar Facet Injection at the Right L5 and S1 Levels under Fluoroscopic Guidance between 07/10/13 and 09/08/13

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

The reviewer is certified by the American Board of Orthopaedic Surgeons with 42 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 medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

04/30/13: MRI Lumbar Spine without Contrast report
05/09/13: Record Review
05/14/13: Followup Evaluation
06/07/13: Office Visit
06/11/13: Preauthorization Request
06/13/13: Telephone Conference
06/14/13: UR performed
07/03/13: Orthopedic Report
07/10/13: Request for reconsideration
07/10/13: Acknowledgment of request for reconsideration
07/18/13: UR performed
07/23/13: Office Visit

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who injured his low back while working on xx/xx/xx.

04/30/13: MRI Lumbar Spine without Contrast report. IMPRESSION: At the L4-L5 level, there is a broad-based central disc protrusion (herniation) extending 1 mm posteriorly producing effacement of the thecal sac.

05/09/13: The claimant's records were reviewed who concluded that the 1-mm herniation or protrusion found on his MRI likely reflected that it was pre-existing. He was diagnosed with lumbosacral sprain. concluded that the MRI findings of a 1-mm disc protrusion at the L4-L5 level were not causally related to the claimant's injury. He noted that the treatment should consist of rest and over-the-counter non-steroidal anti-inflammatory drugs or Tylenol for pain. He also noted that physical therapy would be indicated at 10 visits over 5 weeks.

05/14/13: The claimant was evaluated for low back pain rated 8/10. He described his pain as sharp and pinching sensation aggravated with sitting and standing and alleviated with resting. He had been taking medication, which did give him some pain relief. On physical exam, he had myospasm, tenderness, and trigger points noted moderate along the lumbar paraspinal bilaterally and bilateral sacroiliac joints. SLR positive bilaterally. Kemp's testing positive bilaterally. Yeoman's testing positive bilaterally. ROM: Lumbar spine flexion 40/60 degrees, extension 10/25 degrees, LLF 10/25 degrees, RLF 10/25 degrees. DTRs were +2 at the upper and lower extremities. Motor testing was +5 in the upper and lower extremities. It was noted that his injuries were a direct result of a 02/09/12 auto accident. The plan was to complete a course of physical therapy and remain off work.

06/07/13: The claimant was evaluated for low back pain rated 7-8/10. On examination, he had a normal, non-antalgic gait. There was tenderness to palpation in the thoracic and lumbar spine. There was moderate muscle spasm. Paraspinous muscle tone was normal. ROM was moderately restricted with rotation. Muscle testing was 5/5 at the quadriceps bilaterally and 4/5 at the knee extensors and flexors bilaterally. SLR positive for back pain only bilaterally. Lumbar x-rays showed a normal exam. He was diagnosed with lumbar disc displacement. It was noted that he continued with primarily axial back pain. It was noted that conservative treatment including PT, NSAIDS, and muscle relaxants had been tried with little or no effect. No surgical procedure was anticipated for the lumbar spine but medial branch block would result in recommendation for radiofrequency rhizotomy. Proceed with MBB.

06/14/13: UR performed. REVIEWER COMMENTS: The patient is a male who sustained injury on xx/xx/xx. He is currently diagnosed with lumbar disc displacement. A request was made for a lumbar facet injection at the right L5 and S1. A lumbar MRI on 04/30/13 showed a broad-based central disc protrusion (herniation) extending 1 mm posteriorly producing effacement of the thecal sac at L4-L5. On 06/07/13, the patient presented with complaints of low back pain that occasionally radiates to both hips. He was stated to have no current medications. Lumbar x-rays showed normal lumbar lordosis, no fractures/subluxation. This report also noted that he has tried PT, NSAIDs, and muscle relaxants that gave little or no effect. The physical examination showed an obese individual (BMI-

34.2) with a non-antalgic gait, normal heel-and-toe walk, tenderness over the thoracic and lumbar spinous processes, moderate muscle spasm, moderated restriction in lumbar lateral flexion, weakness (4/5) of the bilateral knee extensor and flexor. SLR test produced bilateral back pain only. A sensory examination of the lower extremities was, however, not documented. The current objective findings do not suggest facet joint pathology specifically to the right L5 and S1. It is noted that a rhizotomy is contemplated once the injections are successful. However, given the current clinical data, the medical necessity of the request is not established at this point.

07/03/13: noted that he evaluated the first denial letter regarding the recommended medial branch block to the claimant's lumbar spine. states that the claimant does meet ODG indications to proceed with this intervention stating that he had tenderness upon palpation in the paravertebral areas, mostly over the facet joint. He had a normal sensory exam. There were no radicular findings and SLR were normal.

07/10/13: UR performed. REVIEWER COMMENTS: No prior lumbar surgery has been performed pertaining to the injury according to the records reviewed. The request for an appeal for one lumbar facet injection at the right L5 and S1 level under fluoroscopic guidance is not supported at this time. The request was previously non-certified on 06/14/13 due to lack of objective physical examination findings and diagnostic evidence of facet pathology. The request remains not certified. No additional documentation has been provided for review. The claimant has physical examination findings noting 4/5 weakness of the bilateral knee extensors and flexors with documentation of subjective reports or axial and lower extremity radicular symptoms. True objective physical examination findings of facet mediated pain have not been provided. The lumbar MRI documents evidence of a broad-based central disc herniation at L4-L5 with effacement of the thecal sac and no documentation of L5 or S1 facet arthropathy. Without clinical physical examination findings suggesting facet mediated pain with diagnostic documentation of facet arthropathy, a lumbar facet injection would not be supported. The claimant has physical examination findings and diagnostic evidence of disc herniation with possible clinical radiculopathy on examination; therefore, facet injection cannot be supported as it is not within the guideline treatment recommendations.

07/23/13: The claimant was evaluated for throbbing pain in the lumbar region. The pain was 7-7.5/10. Medications included Tylenol, naproxen, and ibuprofen. Height 64", weight 209 lbs. MBI 35.9. On exam, he had a normal gait. He had tenderness to palpation in the thoracic and lumbar spine. He had moderate spasm. Muscle testing was 5/5 with the exception of 4/5 knee flexor and extensor bilaterally and 2/4 patellar reflex bilaterally. SLR positive for back pain only bilaterally. It was noted that he had a designated doctor visit after his last office visit. He complained of primarily axial mechanical back pain. It was noted that "we are attempting to treat his back pain with diagnostic medial branch blocks."

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

The previous adverse decisions are upheld. No clinical evidence of facet joint arthropathy is noted. There is no x-ray or MRI evidence of facet pathology. He does not meet the ODG criteria for clinical presentation consistent with facet joint pain, signs, and symptoms. There is a lack of physical or imaging evidence of facet joint arthropathy. Therefore, the request for Lumbar Facet Injection at the Right L5 and S1 Levels under Fluoroscopic Guidance between 07/10/13 and 09/08/13 is not medically necessary and is not certified.

ODG:

Facet joint diagnostic blocks (injections)	<p>Criteria for the use of diagnostic blocks for facet “mediated” pain: Clinical presentation should be consistent with facet joint pain, signs & symptoms.</p> <ol style="list-style-type: none"> 1. One set of diagnostic medial branch blocks is required with a response of $\geq 70\%$. 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. (Franklin, 2008)]
Facet joint injections, multiple series	<p>Not recommended.</p> <p><i>Diagnostic blocks:</i> One set of medial branch blocks is recommended prior to a neurotomy. Intra-articular blocks are not recommended as the diagnostic procedure. Confirmatory blocks, while recommended for research studies, do not appear to be cost effective or to prevent the incidence of a false positive response to the neurotomy procedure itself. See Facet joint diagnostic blocks (injections).</p> <p><i>Therapeutic injections:</i> With respect to facet joint intra-articular therapeutic injections, 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). See Facet joint intra-articular injections (therapeutic blocks). There is no peer-reviewed literature to support a “series” of therapeutic fact blocks.</p>
Facet joint medial branch blocks	<p>Not recommended except as a diagnostic tool. Minimal evidence for treatment. <i>Pain Physician 2005:</i> In 2005 <i>Pain Physician</i> published an article that stated that</p>

(therapeutic injections)	<p>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 <i>Pain Physician</i>.] The average relief per procedure was 11.9 ± 3.7 weeks.</p> <p><i>Pain Physician 2007</i>: 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).</p>
Facet joint intra-articular injections (therapeutic blocks)	<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.

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)**