

CASEREVIEW

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Notice of Independent Review Decision
[Date notice sent to all parties]: January 23, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Facet Joint Injection at the bilateral L4-L5 and L5-S1 with Intravenous Sedation between 12/21/2012 and 3/21/2013.

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

This physician is a Board Certified Orthopedic Surgeon 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 medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

11/08/06: Preoperative Assessment by MD
11/09/06: Operative Report by MD
11/09/06: Operative Report by MD
06/22/11: Follow-Up Evaluation
09/20/11: Follow-Up Evaluation
10/11/11: IME by MD
12/12/11: Follow-Up Evaluation
05/29/12: Follow-Up Evaluation by
11/05/12: Follow-Up Evaluation

11/26/12: Follow-Up Evaluation
11/29/12: MRI Lumbar Spine w/o Contrast
12/10/12: Follow-Up Evaluation
12/17/12: UR performed by MD
12/27/12: UR performed by MD

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male. He was involved in an incident at work and was treated with injections and underwent an L5-S1 discectomy. On XXXX, he was adjusting a seat and injured his back again. According to the medical records he had Discography on March 13, 2000 which revealed grade 5 annular tear at L5-S1 and internal fissure posterolateral at L4-5. It was then reported that he had an MRI on August 24, 2001 that showed he had a prior laminectomy at the level of L5 with scar tissue on the right. He underwent an IDET procedure on May 20, 2002 by Dr. Henderson. A post discogram CT of the lumbar spine on September 18, 2002 revealed a broad-based posterior fissure at L5-S1. There was also note of a Lumbar MRI on July 2, 2010 that noted a subtle, left-sided superficial annular fissure not associated with disc protrusion at L4-5 and L5-S1, and there was surgical hardware noted in the intervertebral disc space.

On November 9, 2006, operative report: Postoperative Diagnosis: Internal disc derangement and degenerative disc disease. Procedure: Anterior exposure of L5-S1 disc space.

On November 9, 2006, operative report: Postoperative Diagnosis: Status post right lumbar laminectomy with significant degenerative disc disease, right sided L5-S1 discectomy with chronic low-back pain secondary to symptomatic degenerative disc disease. Procedure: 1. Complete anterior discectomy, L5-S1, with decompression of epidural space and lateral recess. 2. Implantation of size 4 wide Charite, 0 and 7.5 degrees with 9.5 mm poly.

On June 22, 2011, the claimant had a 3 month follow up. The claimant continued to have back pain. He tried lidocaine patches which did not provide him with much relief. He continued to require Hydrocodone approximately 4 times a day.

On September 20, 2011, the claimant was re-evaluated for continued low back pain. On physical examination he had a normal gait. Patellar reflexes were symmetric. Achilles reflexes were symmetric. Manual motor testing was 5/5 throughout bilateral lower extremities. Seated straight leg raising was negative bilaterally. He had pain with forward flexion as well as with extension. Medication was refilled.

On December 12, 2011, the claimant was re-evaluated for an increase of severe lower back pain which began radiating down bilateral legs, right worse than left. Hydrocodone was only providing him with minimal relief. On physical exam he

could walk on his toes as well as his heels. He did have tenderness to palpation in his lumbar spine. He had limited forward flexion and extension secondary to pain. Right and left lateral bending caused him discomfort as well. Patellar reflexes were symmetric. Achilles reflexes were symmetrically diminished. Manual motor testing was 5/5 throughout bilateral lower extremities. Seated straight leg raise on the left at approximately 40 degrees produced pain in his lower back, on the right at 50 degrees produced pain in his lower back. Plan: He was placed on a Medrol Dosepak. Hydrocodone was continued. He was also placed on Flexeril 10 mg. X-rays were performed and showed good placement of his disk at L5-S1. He did have some minor loss of disk height at 4-5. He did not demonstrate any signs of instability with forward flexion or extension.

On November 5, 2012, the claimant was re-evaluated by Dr. for continued low back pain. The claimant also reported that over the last month his left leg pain was worse. On physical exam his deep tendon reflexes were symmetric at the knees and ankles. Sitting root test was negative on the right but on the left he complained of pain. There was no significant paraspinal spasm. X-rays performed in the office showed his disc replacement was in good position and with good motion at L5-S1. There may be some narrowing at the L4-5 level. Plan: Placed on Lyrica 1 tablet twice a day, 75 mg. New prescription for Hydrocodone. Obtain a new MRI of the lumbar spine.

On November 26, 2012, the claimant was re-evaluated for increased lower back pain with pain radiating into his left lower extremity. He noted a flare up in his back after trying to lift a small box on 11/23/2012. He went to the emergency room on 11/24/2012 and he was given 2 injections which gave him no relief. He was released with a Medrol Dosepak. He reported weakness in his lower extremity. On physical examination paravertebral muscles were tender on the left with spasms to the left. Lumbar range of motion was painful and restricted in extension, lateral bending to the left was painful. Straight leg raises were normal on the right with no issues. Straight leg raise was positive on the left side at 75 degrees. Pain with seated straight leg raise that was located at back. Lower extremities strength was symmetrically present in all lower extremity muscle groups. Current left ankle reflex was normal. Current left knee reflex was absent. Plan: MRI lumbar spine.

On November 29, 2012, MRI of the Lumbar Spine, Impression: 1. Ferromagnetic artifact substantially obscures and distorts the L5 and S1 levels. There does not appear to be central spinal canal stenosis at this level. The lateral recesses and foramina are distorted. There does not appear to be a high-grade foraminal stenosis. 2. Disc bulging at L4-5 is present without central spinal canal stenosis, foraminal stenosis appears mild on the right and mild to moderate on the left.

On December 10, 2012, the claimant was re-evaluated for continued severe low back pain with bilateral leg numbness. He still reported weakness in his lower extremities. On physical examination paravertebral muscles were tender on the left with spasms to the left. Lumbar range of motion was painful and restricted to

the following, extension was painful, lateral bending to the left was painful. Straight leg raise was normal on the right side. Straight leg raise was positive on the left side at 75 degrees. Pain with seated straight leg raise. Lower extremity strength was symmetrically present in all lower extremity muscle groups. Left ankle reflex was normal and left knee reflex was absent. Assessment: Status post disc replacement at L5-S1 with significant increase in lower back pain with bilateral numbness. Plan: "The patient does have significant pain with extension and does demonstrate facet arthropathy on his MRI, I believe the patient would benefit from bilateral facet injections to be performed at the L4-5 level to see if this provides him with this".

On December 17, 2012, MD performed a UR. Rationale for Denial: The records reflect the long and complicated history of this claimant's back injury. He has undergone a number of treatments for his back pain, including discectomy, laminectomy and disc replacement involving the L5-S1. Despite this, he remains with back pain. The latest report dated 12/10/12 indicates severe low back pain with bilateral leg numbness. Physical examination indicated tenderness of the back on the left with painful and restricted lumbar spine range of motion. The SLR test was indicated to be positive on the left at 75 degrees. Lower extremity strength was indicated to be "symmetrically present" in all lower extremity muscle groups. The left knee reflex was absent. Considering that the claimant's complaints have radicular component (lower extremity numbness), and previous treatments were directed for radiculopathy (ESIs), and objective and comprehensive neuro-sensory examination to illustrate a non-radicular pain generator to support the requested facet block was not provided. Guidelines also indicate that IV sedation should only be considered for cases of extreme anxiety, a condition which the records did not reflex to be present or occurred in the past with this patient. As such, the medical necessity of the requested service has not been substantiated.

On December 27, 2012, MD performed a UR. Rationale for Denial: The clinical documentation evidences upon physical exam of the patient, objective findings of radiculopathy symptoms were noted. Guidelines indicate facet joint injections are recommended for patients with low back pain that is non-radicular in origin and at no more than 2 levels bilaterally. The clinical notes evidence the patient has previously utilized epidural steroid injections for his radiculopathic complaints. Furthermore, the clinical notes lack evidence of the patient presenting with facet mediated pain. Additionally, as evidenced in the previous adverse determination, 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, the patient presenting with this condition was noted in documents. Furthermore, on the clinical note dated 12/10/2012, the provider documented a recommendation of the patient to undergo an injection at the L4-5 level. The clinical note did not evidence the provider the patient undergo a facet joint injection at the L5-S1 level. Given all the above, the request for 1 facet joint injection at the bilateral L4-5 and L5-S1 with intravenous sedation is non-certified.

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

The previous adverse determinations are upheld. According to ODG criteria, Facet Joint Injections should be limited to patients with low-back pain that is non-radicular. ODG also lists as part of the criteria, "There should be no evidence of radicular pain, spinal stenosis, or previous fusion." The Lumbar MRI from November 29, 2012 reported mild foraminal stenosis on the right and mild to moderate on the left at the L5-S1 level. On December 10, 2012, the claimant was re-evaluated by XXXXX who found on physical examination straight leg raise was positive on the left side at 75 degrees. There was also pain with seated straight leg raise. Left knee reflex was also absent. The claimant also presented at that time with an increase in lower back pain with bilateral numbness. These physical findings indicate a radicular component. After reviewing the records, the claimant's back pain appears to be multifactorial, with no indication on specific facet mediate pain. The request also included Intravenous Sedation which is recommended to only be given in cases of extreme anxiety. The medical records did not indicate that the claimant suffers from extreme anxiety. Therefore, based on all the above, the request for Facet Joint Injection at the bilateral L4-L5 and L5-S1 with Intravenous Sedation between 12/21/2012 and 3/21/2013 is not found to be medically necessary.

PER ODG:

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 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](#))]

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 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)**