

IRO REVIEWER REPORT TEMPLATE -WC

INDEPENDENT REVIEWERS OF TEXAS, INC.

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Notice of Independent Review Decision

[Date notice sent to all parties]:

06/19/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: 1 bilateral L3 -L4 and L4-L5 Facet Blocks, as an outpatient between 4/19/2013 and 6/3/2013

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

REVIEW OUTCOME:

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

X Upheld (Agree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Cover sheet and working documents
Utilization review determination dated 04/25/13, 05/14/13
MRI of the lumbar spine dated 05/01/12
Office visit note dated 03/15/13, 04/15/13, 04/30/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male whose date of injury is xx/xx/xx. MRI of the lumbar spine dated 05/01/12 revealed at L3-4 facet arthrosis and ligamentum flavum hypertrophy with osteophytic ridging and mild canal and foraminal stenosis. At L4-5 there is osteophytic ridging and disc bulging with facet arthrosis. There is mild lower neural foraminal impingement on the right and moderate impingement on the left. The patient has undergone left laminotomy with enhancing epidural fibrosis in the lateral recess on the left and there is moderate to moderately severe canal stenosis. There is a gap in the treatment records until office note dated 03/15/13. The patient has been going through physical therapy. He still has back pain. The radicular pain he used to have before surgery is gone. He still has 20% of lingering numbness on the left lateral lower leg. The patient is being scheduled to go through a chronic pain management program. Note dated 04/15/13 indicates that the patient is going through chronic pain management. He is participating through all the programs; however, his back is not getting better. The patient was recommended to undergo L3-4 and L4-5 facet block. Note dated 04/30/13 indicates that the patient is going to chronic pain management twice a week. He is now trying to lose weight. On physical examination extension and rotation of his back increases his pain.

Initial request for bilateral L3-4 and L4-5 facet blocks was non-certified on 04/25/13 noting that there is no documentation of pain with extension and rotation of the spine, increased pain when sitting or standing or decreased range of motion. Additionally, the levels and amount of injections is excessive. The denial was upheld on appeal dated 05/14/13 noting that there are no diagnostic interventions outlined. The pain is noted to be in the lower extremity which makes this radicular in nature. The prior conservative measures have not been outlined; however, it is indicated that there has been a failure of conservative treatment. Additionally, there is no documentation of any pain relief with any intervention. Lastly, a lumbar fusion has been suggested and would speak against performing such facet blocks.

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

Based on the clinical information provided, the request for 1 bilateral L3- and –L facet blocks is not recommended as medically necessary. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. There is no current, detailed physical examination submitted for review to establish the presence of facet-mediated pain. The patient presents with a diagnosis of lumbar radiculopathy. The Official Disability Guidelines note that facet blocks are limited to patients with low back pain that is non-radicular. Given the current clinical data, the requested blocks are not indicated as medically necessary.

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

X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

ODG Low Back Chapter

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| Facet joint diagnostic blocks (injections) | <p>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). Although it is suggested that MBBs and intra-articular blocks appear to provide comparable diagnostic information, the results of placebo-controlled trials of neurotomy found better predictive effect with diagnostic MBBs. In addition, the same nerves are tested with the MBB as are treated with the neurotomy. The use of a confirmatory block has been strongly suggested due to the high rate of false positives with single blocks (range of 25% to 40%) but this does not appear to be cost effective or to prevent the incidence of false positive response to the neurotomy procedure itself. (Cohen, 2007) (Bogduk, 2000) (Cohen2, 2007) (Mancchukonda, 2007) (Dreyfuss, 2000) (Manchikanti2, 2003) (Datta, 2009)</p> <p><i>Etiology of false positive blocks:</i> Placebo response (18-32%), use of sedation, liberal use of local anesthetic, and spread of injectate to other pain generators. The concomitant use of sedative during the block can also interfere with an accurate diagnosis. (Cohen, 2007)</p> <p><i>MBB procedure:</i> The technique for medial branch blocks in the lumbar region requires a block of 2 medial branch nerves (MBN). The recommendation is the following: (1) L1-L2 (T12 and L1 MBN); (2) L2-L3 (L1 and L2 MBN); (3) L3-L4 (L2 and L3 MBN); (4) L4-L5 (L3 and L4 MBN); (5) L5-S1: the L4 and L5 MBN are blocked, and it is recommended that S1 nerve be blocked at the superior articular process. Blocking two joints such as L3-4 and L4-5 will require blocks of three nerves (L2, L3 and L4). Blocking L4-5 and L5-S1 will require blocks of L3, L4, L5 with the option of blocking S1. (Clemans, 2005) The volume of injectate for diagnostic medial branch blocks must be kept to a minimum (a trace amount of contrast with no more than 0.5 cc of injectate), as increased volume may anesthetize other potential areas of pain generation and confound the ability of the block to accurately diagnose facet pathology. Specifically, the concern is that the lateral and intermediate branches will be blocked; nerves that innervate the paraspinal muscles and fascia, ligaments, sacroiliac joints and skin. (Cohen, 2007) Intraarticular blocks also have limitations due to the fact that they can be technically challenging, and if the joint capsule ruptures, injectate may diffuse to the epidural space, intervertebral foramen, ligamentum flavum and paraspinal musculature. (Cohen, 2007) (Washington, 2005) (Manchikanti, 2003) (Dreyfuss, 2003) (BlueCross BlueShield, 2004)</p> |
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([Pneumatics, 2006](#)) ([Boswell, 2007](#)) ([Boswell2, 2007](#)) A recent meta-analysis concluded that there is insufficient evidence to evaluate validity or utility of diagnostic selective nerve root block, intra-articular facet joint block, medial branch block, or sacroiliac joint block as diagnostic procedures for low back pain with or without radiculopathy. ([Chou2, 2009](#)) This study suggests that proceeding to radiofrequency denervation without a diagnostic block is the most cost-effective treatment paradigm, but does not result in the best pain outcomes. ([Cohen, 2010](#)) See also [Facet joint pain, signs & symptoms](#); [Facet joint radiofrequency neurotomy](#); [Facet joint medial branch blocks](#) (therapeutic injections); & [Facet joint intra-articular injections](#) (therapeutic blocks). Also see [Neck Chapter](#) and [Pain Chapter](#).

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](#))]