

Notice of Independent Review Decision

DATE OF REVIEW: June 4, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar facet injection under fluoroscopy with IV sedation level L3-4 through L5-S1, (64493-50, 64494-50, 64495-50)

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

This case was reviewed by a physician who holds a board certification in Anesthesiology with sub-specialty in Pain Medicine. The reviewer is licensed and currently practicing in the state of Texas.

REVIEW OUTCOME

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

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Type of Document Received	Date(s) of Record
Bone Scintigram	
MRI of the lumbar spine	11/24/2009
Operative report (lumbar ESI)	04/02/2012
Operative report	07/05/2012
Office visit	09/27/2012
Initial pain evaluation	11/09/2012
Follow up note	03/08/2013
Follow up note	03/21/2013
A letter regarding denial of requested service	04/01/2013
Follow up note	04/01/2013
A second letter regarding denial of requested service	04/25/2013



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A third letter regarding denial of requested service	05/08/2013
A fourth letter regarding denial of requested service	05/20/2013
An IRO request for the denied services of "Lumbar facet injection under fluoroscopy with IV sedation level L3-4 through L5-S1, (64493-50, 64494-50, 64495-50)"	05/23/2013
	05/28/2013

EMPLOYEE CLINICAL HISTORY [SUMMARY]:

This is a male who sustained a lower back injury on xx/xx/xx while he was pulling and felt a pull in his lower back with pain down his leg associated with numbness and weakness. He had a lumbar MRI done that showed disc protrusion at L4-5 with mild spinal stenosis and foraminal narrowing as well as disc protrusion at L5-S1 contacting the right traversing S1 nerve root with minimal displacement. Subsequently, he had lumbar ESI done on 07/05/2013 without much relief in his symptoms. He eventually underwent lumbar discectomy, laminotomy, and facetectomy at L4-5 and L5-S1 but continues to report lower back and right foot pain with numbness and tingling down his right foot/leg. On 11/09/2012, he was seen and was referred for pain management and postop rehab. He was then seen at which time he reported right lower lumbar spine pain at L3-4 through L5-S1 worse with extension and bending activities. He reported his pain level was 7-8/10. referred him for lumbar facet injection therapy from L3-4 through L5-S1.

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

Lumbar facet pain can be acute or chronic. is XX and it is possible he has chronic degenerative changes in his spine, which is unrelated to his injury on 03/08/2012. In that case the MRI would show enlarged facet joint indicating arthritis and it probably is not related to his injury.

(reference- Interventional Pain Management by Waldman and Winnie 1996, page 191)

His MRI lumbar spine 04/02/2012 showed no significant facet arthropathy, just mild facet arthropathy at L5-S1. In that case the facet pain is traumatic, secondary to his injury. On exam, he did present with facet pain with increased pain on spine extension and bending sideways and paraspinal pain over the facet joints with palpation. Therefore, the facet joint injections are justified.

One other concern is the surgery performed on 09/27/2012 which includes facetectomy and it is not clear if the facet joints are intact at the L4-5 and L5-S1 levels for injection.



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Facet joint pain could be treated in two ways. One is blocking the medial branch, a nerve that innervates the facet joint. This is a diagnostic procedure. ODG Guideline for facet Joint discussed diagnostic medial branch injections, which may not require sedation.

A second way to treat facet pain is to inject the facet joint. It is a therapeutic procedure. The case proposed here is a therapeutic joint injection. ODG guideline does not disallow IV sedation. If the patient goes for facet joint injections, he should have IV sedation if he wishes.

ODG CRITERIA FOR FACET INJECTIONS

Facet joint diagnostic blocks (injections)

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) (Manchukonda, 2007) (Dreyfuss, 2000) (Manchikanti2, 2003) (Datta, 2009)

Etiology of false positive blocks: 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)

MBB procedure: 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



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flavum and paraspinal musculature. (Cohen, 2007) (Washington, 2005) (Manchikanti , 2003) (Dreyfuss, 2003) (BlueCross BlueShield, 2004) (Pneumaticos, 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)]



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**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)

(Interventional Pain Management by Wildman and Winnie 1996, page 191)