

# AccuReview

An Independent Review Organization

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Notice of Independent Review Decision

**[Date notice sent to all parties]:** February 22, 2013

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

1 Facet Injection at the Bilateral L2-L3 and L3-L4 Levels with Fluoroscopy between 11/19/2012 and 1/18/2013

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

This physician is Board Certified Physical Medicine and Rehabilitation with over 16 years of experience.

**REVIEW OUTCOME:**

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

Overturned (Disagree)

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:**

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a male that complains of lower back pain and bilateral feet numbness that has progressively worsened since a fall he sustained while working on xx/xx/xx. He was injured while he was walking up the steps and the bottom step gave way and he fell backwards initially landing on his feet then on his tailbone and lower back area.

09-14-12: X-Ray Lumbar Spine, Three View. Impression: 1. Mild lumbar spondylosis with facet hypertrophy present at L4-L5 and L5-S1. 2. Extensive atherosclerotic calcification of the abdominal aorta. 3. Partially visualized are bilateral total hip arthroplasties.

09-18-12: Visit Summary. Diagnosis: sprain lumbar region 847.2, other back symptoms 724.8, contusion trunk NOS 922.9. Work status: claimant condition

has not improved; continue work with restriction and medications as directed. Follow up on 9/25/12.

09-21-12: MRI Coccyx. Impression: 1. Subcutaneous edema is present superficial to the sacrum and the coccyx. 2. No evidence of coccyx fracture or bone contusion. 3. Please see the separately reported MRI of the sacrum.

09-21-12: MRI Lumbar Spine. Impression: 1. There are facet joint effusions at L1-2, L2-3, and L3-4 indicative of acute facet joint irritation and lumbar facet syndrome. 2. L1-2, L2-3: no evidence of disc herniation, canal stenosis or neural foraminal encroachment. 3. L3-4, L4-5, L5-S1: broad 1 mm disc bulge.

09-21-12: MRI Sacrum. Impression: 1. Mild sacral bone contusion from the patient's injury without evidence of cortical fracture. 2. Subcutaneous edema is present overlying the sacrum for the patient's injury as well.

09-27-12: Visit Summary. Diagnosis: sprain lumbar region 847.2, other back symptoms 724.8, contusion trunk NOS 922.9. Treatment: Physical therapy ordered 3 times per week for 2 weeks. Work status: claimant condition has not improved; continue work with restriction and medications as directed. Follow up on 10/2/12 and 10/11/12.

10-25-12: Letter. Chief complaint: lower back pain. Claimant rated his pain 8/10 and ranges 3-9/10, described as a sharp, stabbing, dull, aching, and burning discomfort in his bilateral lower back area. He also complains of bilateral distal toe numbness that began approximately two weeks ago. His symptoms are aggravated mostly by walking, sitting, and bending forward at the waist. He is able to tolerate walking for five minutes and sitting for 30 minutes. His symptoms are improved with lying flat on his back. He recently began physical therapy and has completed two sessions, which he stated aggravated his lower back pain. He is currently taking naproxen, Tramadol, and Flexeril with no significant pain relief. The claimant's lower back pain is secondary to lumbar facet syndrome that affects the L2-L3, L3-L4 facets that is evident on his physical exam and recent lumbar

imaging. On physical examination, he had decreased range of motion with extension. Positive bilateral lumbar lower paraspinals and lumbar facet tenderness at the L2-L3 and L3-L4 level. Positive bilateral facet loading pain. Treatments discussed include: anti-inflammatories, pain medications, topical ointments, and lumbar medial branch blocks/rhizotomy at L2-3 and L3-L4. The medical branch blocks will be diagnostic and radiofrequency ablation will be therapeutic and is supported by the guidelines.

11/08/12: Office Visit. Chief complaint: lower back pain. Claimant has over the past month completed ten sessions of physical therapy with mild improvement and is currently taking Mobic and Tramadol with no significant pain improvements. He stated that his prior pain medication of hydrocodone was improving his pain control. Claimant is continuing HEP and using a back brace and TENS unit with mild improvement. Assessment: 1. Lumbar facet syndrome at L2-L3 and L3-L4. 2. Sacrum/coccyx contusion. 3. Lumbar sprain. Plan: Proceed with lumbar L2-L3 and L3-L4 facet medical branch blocks/rhizotomy as recommended. Continue with Mobic 50 mg PO daily to improve inflammatory pain. Discontinue Ultram and begin Norco 10/325 mg one tablet PO Q8hr PRN pain. Claimant to continue PT and HEP to improve lumbar cord strengthening, lumbar ROM and HEP.

11-21-12: UR performed. Reason for denial: This is a request for one Facet Injection at the bilateral L2-L3 and L3-L4 levels with Fluoroscopy. The medical report dated 11-8-12, states that the claimant complains of lower back pain and bilateral feet numbness that has progressively worsened since the fall he sustained on 9-12-12. The pain ranges from 5-10/10 and is described as throbbing, dull, aching and sharp discomfort localized to the lower back. There is associated intermittent numbness and tingling on the bilateral distal feet and thigh areas. Physical examination showed normal alignment of the lumbar spine and mild tenderness to palpation of the bilateral middle or lower paraspinals. Flexion and extension is full with pain at end of flexion. Facet loading at bilateral lower spinals is positive. The SLR test is negative at the seated and supine positions. Sensation is mildly decreased at the left dorsal foot and right anterior thigh. Gait is mildly antalgic bilaterally. A lumbar spine MRI dated 9/21/12 revealed facet joint effusion at L2-L3 and L3-L4. The clinical information obtained from the report dated 11/8/12 is not consistent with the diagnosis of facet joint pain as associated symptoms of intermittent numbness and tingling on the bilateral distal feet and thigh areas were reported, with findings of mildly decreased sensation at the left dorsal foot and anterior thigh. It is noted with the patient, to which he has agreed to proceed with. Based on these grounds, the medical necessity of the requested one Facet Injection at the bilateral L2-L3 and L3-L4 levels with fluoroscopy has not been established and is non-certified.

11-29-12: Follow-up Visit dictated. Chief complaint: lower back pain. Claimant has completed 10 sessions of PT which aggravated his lower back pain. He is currently taking Mobic, Lyrica, hydrocodone, and Flexeril with mild pain relief. PE: Lumbar spine, normal alignment. Increased lumbar flexion to 60 degrees and decreased extension to 5 degrees. Bilateral lumbar facet loading pain. Tenderness to palpation of the midline of lower lumbar spinous process from L1 to

L5. Moderate tenderness to palpation over the bilateral lower paraspinous tissues at L2-3 and L3-4 facets. Assessment: 1. Lumbar facet syndrome at L2-L3 and L3-L4. 2. Sacrum/coccyx contusion. 3. Lumbar sprain. Plan: Proceed with lumbar L2-L3 and L3-L4 facet medical branch blocks/rhizotomy as recommended. Continue with Mobic 50 mg PO daily to improve inflammatory pain. Continue Lyrica 75mg PO BID as tolerated to improve his neuropathic pain. Continue Norco 10/325 mg one tablet PO Q8hr PRN pain. Begin Robaxin 750 mg PO TID PRN muscle spasms. Claimant to continue home physical therapy as tolerated to improve his lumbar core strengthening, lumbar ROM and HEP. Follow up two weeks after his lumbar rhizotomy.

12-18-12: UR performed. Reason for denial: Records indicate an adverse determination to a previous review. In acknowledgement of the prior non-certification due to lack of documentation of a 11-29-12 medical report which states that the patient complains of lower back pain with associated bilateral feet numbness, which has progressively worsened since 9-12-12. His current pain is rated 4-10/10 and is described as sharp, stabbing, dull, aching, throbbing and burning discomfort. Physical examination of the lumbar spine showed decreased extension, bilateral lumbar facet loading pain, tenderness to palpation, and intact motor and sensory examinations. The bilateral Achilles reflex if ¼. The patient's gait is antalgic secondary to the lower back pain. It is noted the lumbar facet medical branch blocks/rhizotomy were discussed with the claimant, to which he agreed to proceed with. The treatment to date includes activity modification, medication, TENS, physical therapy. However, there is no clear documentation of failure of conservative treatment prior to the procedure for at least 4-6 weeks. Therefore, the medical necessity of this request has not been sustained and is non-certified.

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

Denial of the previous adverse determinations for bilateral facet injections at L2-3, L3-4 is overturned; disagreed with. Submitted clinicals do meet ODG criteria with symptoms and signs of facet mediated pain (decreased lumbar extension with pain, positive tender/facet loading, MRI with facet effusions), 4-6 weeks of conservative care (medications, physical therapy, and home exercise program), and no more than two levels bilaterally. Pain pattern/numbness and MRI do not suggest a radicular/nerve root distribution. Therefore, after reviewing the medical records and documentation provided, the request for 1 Facet Injection at the Bilateral L2-L3 and L3-L4 Levels with Fluoroscopy between 11/19/2012 and 1/18/2013 is medically necessary and approved.

Per ODG:

Facet joint radiofrequency neurotomy	<p><b>Criteria for use of facet joint radiofrequency neurotomy:</b></p> <p>(1) Treatment requires a diagnosis of facet joint pain using a medial branch block as described above. See <a href="#">Facet joint diagnostic blocks</a> (injections).</p> <p>(2) While repeat neurotomies may be required, they should not occur at an interval of less than 6 months from the first procedure. A neurotomy should not be repeated unless duration of relief from the first procedure is documented for at least 12 weeks at ≥ 50% relief. The current literature does not support that the procedure is</p>
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	<p>successful without sustained pain relief (generally of at least 6 months duration). No more than 3 procedures should be performed in a year's period.</p> <p>(3) Approval of repeat neurotomies depends on variables such as evidence of adequate diagnostic blocks, documented improvement in VAS score, decreased medications and documented improvement in function.</p> <p>(4) No more than two joint levels are to be performed at one time.</p> <p>(5) If different regions require neural blockade, these should be performed at intervals of no sooner than one week, and preferably 2 weeks for most blocks.</p> <p>(6) There should be evidence of a formal plan of additional evidence-based conservative care in addition to facet joint therapy.</p>
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<p>Facet joint medial branch blocks (therapeutic injections)</p>	<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 there was moderate evidence for the use of lumbar medial branch blocks for the treatment of chronic lumbar spinal pain. (<a href="#">Boswell, 2005</a>) This was supported by one study. (<a href="#">Manchikanti, 2001</a>) 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. (<a href="#">Manchikanti2, 2007</a>) 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. (<a href="#">Boswell2, 2007</a>) 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. (<a href="#">Wasan, 2009</a>) The use of the blocks for diagnostic purposes is discussed in <a href="#">Facet joint diagnostic blocks</a> (injections). See also <a href="#">Facet joint intra-articular injections</a> (therapeutic blocks).</p>
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<p>Facet joint pain, signs &amp; symptoms</p>	<p><b>Suggested indicators of pain related to facet joint pathology</b> (acknowledging the contradictory findings in current research):</p> <ol style="list-style-type: none"> <li>(1) Tenderness to palpation in the paravertebral areas (over the facet region);</li> <li>(2) A normal sensory examination;</li> <li>(3) Absence of radicular findings, although pain may radiate below the knee;</li> <li>(4) Normal straight leg raising exam.</li> </ol> <p><i>Indictors 2-4 may be present if there is evidence of hypertrophy encroaching on the neural foramen.</i></p>
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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)**