

# INDEPENDENT REVIEWERS OF TEXAS, INC.

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## Notice of Independent Review Decision

**[Date notice sent to all parties]:**

**09/17/2013**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** lumbar facet injection at bilateral L4-5 and L5-S1, I injection as an Outpatient

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

Board Certified Anesthesiologist; Board Certified Pain Medicine

**REVIEW OUTCOME:**

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

X 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:**

Cover sheet and working documents

Utilization review determination dated 07/15/13, 08/08/13

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female whose date of injury is xx/xx/xx. The mechanism of injury is not described. The patient's diagnosis is lumbago. Current medications include Zipsor, Nexium, Skelaxin, Ibuprofen and hydrocodone. The patient underwent facet injections at L4-5 and L5-S1 bilaterally on 04/09/13. Per evaluation on 07/08/13, the patient presents with subjective complaints of low back and lower extremity radiculopathy, and the facet injections were more effective than epidural steroid injections in overall pain relief. Physical examination notes decreased lumbar range of motion, positive straight leg raising on the right and tenderness to the facet joints.

Initial request for lumbar facet injection at bilateral L4-5 and L5-S1 was non-certified on 07/15/13 noting that the Official Disability Guidelines only support one set of diagnostic facet injections, and this is limited to individuals with low back pain that is non-radicular. This claimant has radicular complaints with radiation into the lower extremities. There is no documentation of any home exercise or physical therapy prior to the procedure for at least four to six weeks. The denial was upheld on appeal dated 08/08/13 noting that there is no reference that the claimant participated in physical therapy. The physical examination did not note specific areas of tenderness, except to say

there was facet tenderness in the lumbar region. Peer review guidelines indicate that prior to consideration of facet joint injections, the pain should be limited to back pain that is non-radicular and at no more than two levels bilaterally. There should be evidence of exhaustion of conservative care including home exercises, physical therapy and use of anti-inflammatory medications for at least 4-6 weeks.

**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 lumbar facet injection at bilateral L4-5 and L5-S1 is not recommended as medically necessary. The patient underwent prior facet injections at L4-5 and L5-S1 on 04/09/13. The Official Disability Guidelines Low Back Chapter supports one set of facet injections and does not support a confirmatory set of injections. The patient’s objective functional response to prior facet injections is not documented. The patient is noted to present with radicular complaints. The Official Disability Guidelines note that facet injections are limited to patients with low back pain that is non-radicular. There are no imaging studies submitted for review. Given the current clinical data, the requested lumbar facet injection at bilateral L4-5 and L5-S1 is not indicated as medically necessary.

**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

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. (<a href="#">Cohen, 2007</a>) (<a href="#">Bogduk, 2000</a>) (<a href="#">Cohen2, 2007</a>) (<a href="#">Manchukonda, 2007</a>) (<a href="#">Dreyfuss, 2000</a>) (<a href="#">Manchikanti2, 2003</a>) (<a href="#">Datta, 2009</a>)</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</p>
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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 flavum and paraspinal musculature. ([Cohen, 2007](#)) ([Washington, 2005](#)) ([Manchikanti , 2003](#)) ([Dreyfuss, 2003](#)) ([BlueCross BlueShield, 2004](#)) ([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](#))]