

CASEREVIEW

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Notice of Independent Review Decision

[Date notice sent to all parties]: June 4, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar Facet Joint Injection under Fluoroscopy at Left L3, L4 and L5 as Outpatient

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

This physician is a Board Certified Anesthesiologist with Pain Management experience for over 6 years.

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:

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was injured on xx/xx/xx. He started having significant back pain. According to the records, he was initially treated who ordered an ESI which gave him good relief for almost xxx years. He then had a return of pain and had 2 additional ESIs that did not provide any significant relief. He then sought treatment.

On November 7, 2011, MRI of the Lumbar Spine, Impression: 1. Mild lumbar spondylosis as above. Posterior annular tear with 2-3 mm posterior disc osteophyte complex at L3-4, L4-5, and L5-S1. 2. No focal disc extrusion or severe central spinal stenosis. 3. Mild to moderate degenerative facet changes no significant foraminal stenosis.

On January 16, 2013, the claimant presented with low back pain with moderate discomfort involving the left lower extremity associated with some altered sensation including numbness and tingling. On physical examination there was mild discomfort to palpation of soft tissue region in the lumbar spine. Lumbar motion was mildly restricted for flexion and extension. There was minimal restriction for bilateral rotation and lateral flexion. There was mild discomfort in bilateral lower paraspinal regions. There was no midline discomfort. Light touch was intact without gross motor deficit. Reflexes were reduced at right ankle. X-rays showed normal segmentation of all lumbar vertebra. All disk space height appeared to be well maintained. Mild spondylitic changes noted throughout. Impression: Lumbar disk syndrome. The importance of a home rehabilitation program was discussed. He was also prescribed Celebrex in addition to the Flexeril.

On November 13, 2013, the claimant presented with recent return of low back pain despite oral medication including Celebrex and rehabilitation efforts. He reported leg pain of the left lower extremity. On physical examination lumbar motion was mildly restricted for flexion and extension. There was minimal restriction for bilateral rotation and lateral flexion. There was mild discomfort in bilateral lower paraspinal regions. There was no midline discomfort. Straight leg raise was positive on the left. MRI was recommended.

On February 25, 2014, the claimant presented for left lower back pain. He denied any pain into the buttocks or lower extremities. It was described that during football season when he is much more active on his job, he will have much more frequent discomfort. He described his pain as an aching type pain with occasional knifelike, sharp pains. His pain is worse with lifting his video camera and with standing for prolonged duration as well as with twisting maneuvers. He has gotten some relief with stretching, ice, relaxation, massage and he does get relief with taking high dose Celebrex intermittently. He has also had chiropractic treatment that gives him some relief. He denied any numbness, tingling or weakness of the lower extremities. On examination he had some mild tenderness to palpation in the left lumbar paraspinals with moderate tenderness to palpation directly over the left L3-4 and L4-5 facet joint levels that reproduces his normal back area pain. He had no tenderness over the right lumbar facets at any level. No tenderness over the SI joints on either side. Back extension to 12 degrees causes mild increased left low back pain. Quadrant loading of the lumbar facets was positive to the left and negative to the right. Pronator extension was equivocal on the left and negative on the right. Back flexion was done without pain and he was able to touch the distal shin level without difficulty. Straight leg raise was negative bilaterally. Reverse straight leg raise was positive in the back only on the left. Patrick's Maneuver was negative. Gait was normal. Sensation was normal and deep tendon reflexes were normal bilaterally. Impression: Back pain. Pain does appear to be mechanical in nature and related to facet joint arthropathy. Recommendations: Change Celebrex to Mobic 15 mg. Left L3-4, and L4-5 facet medial branch diagnostic block.

On March 4, 2014, UR. Rationale for Denial: Based on treatment guidelines, facet joint injections are not supported in individuals with radicular symptoms. The most recent detailed evaluation from November 13, 2013 indicates that the claimant has left leg radicular symptoms. These injections are also not supported as isolated treatment. There is no indication any other therapeutic intervention is being recommended in conjunction with the facet joint injections. It is also uncertain if previous epidural steroid injections or facet joint injections have been accomplished in the past. If they have been accomplished, the benefit of these injections has not been documented. There are also no recent objective physical examination findings supporting positive facet loading or tenderness to palpation over the facet joints to support the medical necessity of this procedure at this time.

On March 14, 2014, UR. Rationale for Denial: Medical records submitted include an MRI dated 11/7/11 and the MRI revealed some mild lumbar spondylosis at multiple levels L3-4, L4-5, and L5-S1 with some degenerative facet changes at multiple levels. A physical examination on 2/25/14 includes a history and physical exam but it does not indicate any physical examination findings indicating any acute neurologic or orthopedic impairments or any specific functional impairment identifying the lumbar spine or lower extremities. There are also no physical examination findings of the lumbar spine indicating that the facets are the pain generators. At this time the request is recommended for noncertification as being not medically reasonable or necessary. The clinical findings do not confirm facet mediated pain or justify the request for facet blocks.

On April 22, 2014, the claimant presented with an acute flare of his left low back pain. He reported he took Meloxicam because of the intense discomfort along with rest and he did receive some improvement but continued having ongoing left low back discomfort. He still denied any pain into the left buttock or left lower extremity. No numbness, tingling or weakness of the lower extremities. On physical examination he had moderate tenderness to palpation over the left lumbar facets at the L3-4, and L4-5 levels. He had a myofascial bands appreciated in the left lumbar paraspinals causing jump sign and also listing significant discomfort consistent with a trigger point. He had no tenderness to palpation over the right lumbar facets at any level. No tenderness over the SI joints. Quadrant loading of the lumbar facets was positive on the left side and negative on the right. Back extension to 10 degrees does cause increase in left-sided low back pain. Prone hip extension was equivocal on the left and negative on the right. With back flexion at the waist, he was able to touch to the distal shin level. Straight leg raise was negative, strength was normal and sensation normal. Recommendations: Continue with Mobic 15mg. Still recommending left L3-4 and L4-5 facet medial branch diagnostic block. Depending on those result, may be a candidate for rhizotomy for long term relief.

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

The previous adverse determinations are upheld. The claimant continues to present with radicular symptoms. Per ODG, facet injections are not recommended for patients with radiculopathy. Additionally, there must be evidence of failed conservative therapy. There is no indication any other therapeutic intervention is being recommended in conjunction with the facet joint injections. There is no documentation of previous ESI or facet joint injections or results from such injections. Physical examination is not congruent with positive facet loading or tenderness to palpation over the facet joints to support the medical necessity of this procedure at this time. Therefore request for lumbar facet joint injection under fluoroscopy at Left L3-L4, L4-L5 and L5-S1 is non-certified.

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](#))]

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)**