

ReviewTex. Inc.
1818 Mountjoy Drive
San Antonio, TX 78232
(phone) 210-598-9381 (fax) 210-598-9382
reviewtex@hotmail.com

Date notice sent to all parties:

March 14, 2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Reconsideration for referral 82627 for lumbar facet block medial branch of the dorsal ramus L4/L5, L5/S1 – right

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

Board Certified Anesthesiology

REVIEW OUTCOME:

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

X 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.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male whose date of injury is XX/XX/XX. The patient was trying to open the door of his truck and felt a sharp pain in his lower back. MRI of the lumbar spine dated XX/XX/XX revealed at L4-5 there is facet arthropathy, ligamentum flavum hypertrophy and circumferential 3-4 mm annular bulge causing moderate acquired central canal stenosis and lateral recess narrowing with anatomic impingement upon the traversing intrathecal L5 nerves and partial effacement of the L5 nerve root sleeve origins. At L5-S1 there is severe facet arthropathy and ligamentum flavum hypertrophy without disc herniation or acquired central canal stenosis. Hypertrophic facet change causes lateral recess narrowing with suspected anatomic impingement upon the traversing foraminal zone segment of bilateral L5 nerve roots. Physical therapy daily note dated

XX/XX/XX indicates that the patient completed 13 physical therapy visits. Office visit note dated XX/XX/XX indicates that the patient complains of low back pain radiating into the right lower extremity. The patient was recommended to undergo diagnostic epidural steroid injection. The patient subsequently underwent lumbar epidural steroid injection on XX/XX/XX. Office visit note dated XX/XX/XX indicates that the patient reported no improvement following the epidural steroid injection. On physical examination straight leg raising is negative. There is pain in the lumbar facets on the right at L5-S1 and L4-5. There is facet pain on spine rotation, extension, flexion and palpation in the lumbar region.

Initial request for lumbar facet block medial branch of the dorsal ramus L4/L5, L5/S1 – right was non-certified on XX/XX/XX noting that there was a request for anesthesia for these injections, but given the need for the pain response relief to be from the injections not from the anesthesia even if the procedure was approvable the anesthesia is not warranted. The ODG does not support the use of facet blocks with radicular symptoms or findings. Office visit note dated XX/XX/XX indicates that the patient definitely has anxiety and fear avoidance with respect to injections. The denial was upheld on appeal dated XX/XX/XX noting that the patient has radicular complaints involving the right lower extremity. This is a contraindication for considering medial branch blocks. ODG does not recommend sedation in conjunction with diagnostic blocks as this can impact the accuracy of the procedure in identifying pain generators.

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 lumbar facet block medial branch of the dorsal ramus L4-5, L5-S1-right is recommended as medically necessary. The patient sustained injuries to the low back on XX/XX/XX as a result of opening a truck door. The patient has been treated with a course of physical therapy. The patient underwent a lumbar epidural steroid injection to address radicular complaints, but noted no improvement with this injection. The patient's physical examination at this time is consistent with facet joint pain, signs and symptoms with tenderness to palpation over the facets as well as pain on extension and rotation. The Official Disability Guidelines would support the use of IV sedation in cases of extreme anxiety. Given the failure of conservative treatment, documentation of facet mediated pain on physical examination and MRI findings, medical necessity is established in accordance with the Official Disability Guidelines.

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 2016

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) The use of sedation during diagnostic injections may increase the rate of false-positive blocks and lead to misdiagnoses and unnecessary procedures, but has no effect on satisfaction or outcomes at 1-month. (Cohen, 2014)

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)]