

February 1, 2006

TX DEPT OF INS DIV OF WC  
AUSTIN, TX 78744-1609

CLAIMANT: \_\_\_

EMPLOYEE: \_\_\_

POLICY: M2-06-0606-01

CLIENT TRACKING NUMBER: M2-06-0606-01

---

Medical Review Institute of America (MRIoA) has been certified by the Texas Department of Insurance as an Independent Review Organization (IRO). The Texas Department of Insurance Division of Workers Compensation has assigned the above-mentioned case to MRIoA for independent review in accordance with DWC Rule 133 which provides for medical dispute resolution by an IRO.

MRIoA has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed. Itemization of this information will follow.

The independent review was performed by a peer of the treating provider for this patient. The reviewer in this case is on the DWC approved doctor list (ADL). The reviewing provider has no known conflicts of interest existing between that provider and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the IRO.

**Records Received:**

Records Received from the State:

- Notification of IRO Assignment, 1/18/06 - 2 pages
- Medical Dispute Resolution Request/Response, 1/18/06 - 3 pages
- Table of Disputed Services, undated - 1 page
- Letter from Patient to Forte, 11/24/05 - 2 pages
- Notice of Utilization Review Findings, 11/11/05 - 2 pages
- Letter from Forte to Patient, 11/11/05 - 1 page
- Notice of Utilization Review Findings, 12/1/05 - 2 pages
- Letter from Forte to Patient, 12/1/05 - 1 page

(continued)

Records Received from Respondent:

- Letter from CAS to MRIOA, 1/23/06 - 1 page
- Letter from Forte to CAS, 1/17/06 - 3 pages
- Letter from Kenneth M. Rosenzweig MD to Injury Management Organization Inc, 10/7/04 - 4 pages
- Office Notes, 4/13/05 - 1 page
- CT Scan Pelvis Radiology Report, 5/4/05 - 1 page
- Texas Workers' Compensation Work Status Report, 4/13/05 - 1 page
- Notice of Utilization Review Findings, 11/11/05 - 3 pages
- Notice of Utilization Review Findings, 12/1/05 - 3 pages
- Duplicate Records, undated - 2 pages

Records Received from Treating Provider:

- Precertification, 11/15/04 - 1 page
- Precertification, 5/18/05 - 1 page
- Office Notes, 11/2/05 - 1 page
- Duplicate Records, undated - 1 page

**Summary of Treatment/Case History:**

Date of injury was \_\_\_\_\_. Diagnosis of spinal stenosis of lumbar region. Patient has central and left sided low back pain and buttock pain that is increased with extension and improved with flexion. Dr. Tibiletti thinks patient has a combination of disc and facet pain. Patient medication from 11/2/05 was Mobic and Lidoderm. CT scan Pelvis 5/4/05 unremarkable.

**Questions for Review:**

Pre auth denied for lumbar facet injection

**Explanation of Findings:**

Pre auth denied for lumbar facet injection

There is conflicting data in the physicians notes, a note from 4/13/05 states patient has more pain in the left piriformis and left SI than the facets. Also recent note on 11/2/05 show no physical findings to support a facet syndrome.

Patient has more signs that support radicular component from a disc displacement.

There is no clear-cut treatment plan. Why does the physician want to do facet injections, followed with epidural steroids? One reason to do facets is for diagnostic purposes, if one does ESI too close to the time of these injections, this decreases the effectiveness of the injection. Another reason to do facets is to decide on if a patient is a candidate for radio ablation this is not documented.

There is conflicting peer review literature support for facet injections as a therapeutics treatment. There is one criteria from the American Society of Interventional Pain Physicians, if a patient receives

(continued)

50% relief for facets for 8 weeks this could be used as palliative treatment. The problem is there is no documentation per the physician that this was the objective. Again if epidural steroids are done too close to this injection one would not know which was effective.

**Conclusion/Decision to Not Certify:**

The lumbar facet injection is not medically necessary.

**References Used in Support of Decision:**

1. The American College of Occupational and Environmental Medicine Guidelines Chapter 12. Invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. Although epidural steroid injections may afford short-term improvement in leg pain and sensory deficits in patients with nerve root compression due to a herniated nucleus pulposus, this treatment offers no significant long-term functional benefit, nor does it reduce the need for surgery. Despite the fact that proof is still lacking, many pain physicians believe that diagnostic and/or therapeutic injections may have benefit in patients presenting in the transitional phase between acute and chronic pain.

2. A critical review of the evidence for the use of zygapophyseal injections and radiofrequency denervation in the treatment of low back pain.

Spine J 2003 Jul-Aug; 3(4): 310-6 (ISSN: 1529-9430)

Slipman CW; Bhat AL; Gilchrist RV; Issac Z; Chou L; Lenrow DA

Penn Spine Center Research Group, Department of Rehabilitation Medicine, Hospital of the University of Pennsylvania, Ground Floor--White Building, 3400 Spruce Street, Philadelphia, PA 19104, USA. slipman@mail.med.penn.edu.

**BACKGROUND CONTEXT:** Lumbar zygapophyseal joints are currently believed to be a cause of axial low back pain. Once this diagnosis is made, decisions about when to institute a particular intervention and which treatment to offer is regionally and specialty dependent. **PURPOSE:** To perform a critical review of prior published studies assessing the use of interventional treatment options for the treatment of lumbar zygapophyseal joint syndrome. **STUDY DESIGN:** Evidence-based medicine analysis of current literature. **METHODS:** A database search of Medline (PubMed, Ovid and MDCConsult), Embase and the Cochrane database was conducted. The keywords used were low back pain, lumbar zygapophyseal joint, lumbar facet joint, radiofrequency denervation, medial branch block, and intra-articular injection. After identifying all relevant literature, each article was reviewed. Data from the following categories were compiled: inclusion criteria, randomization of subjects, total number of subjects involved at enrollment and at final analysis. Statistical analysis used, intervention performed, outcome measures, follow-up intervals and results. Guidelines described by the Agency for Health Care Policy and Research were then applied to these data. **RESULTS:** This review determined that the evidence for the treatment of lumbar zygapophyseal joint syndrome with intra-articular injections should be rated as level III (moderate) to IV (limited) evidence, whereas that for radiofrequency denervation is at a level III. **CONCLUSIONS:** Current studies fail to give more than sparse evidence to support the use of interventional techniques in the treatment of lumbar zygapophyseal joint-mediated low back pain. This review emphasizes the need for larger,

prospective, randomized controlled trials with uniform inclusion and exclusion criteria, standardized treatment, uniform outcome measures and an adequate duration of follow-up period so that definitive recommendations for the treatment of lumbar zygapophyseal joint-mediated pain can be made.

3. Radiofrequency facet joint denervation in the treatment of low back pain: a placebo-controlled clinical trial to assess efficacy.

Spine 2001 Jul 1; 26(13): 1411-6; discussion 1417 (ISSN: 0362-2436)

Leclaire R; Fortin L; Lambert R; Bergeron YM; Rossignol M

Center for Clinical Epidemiology and Community Studies, Sir Mortimer B. Davis, Jewish General Hospital, McGill University, Montreal, Quebec, Canada. laf.lec@sympatico.ca.

STUDY DESIGN: A prospective double-blind randomized controlled trial was performed.

OBJECTIVE: To assess the efficacy of percutaneous radiofrequency articular facet denervation for low back pain. SUMMARY OF BACKGROUND DATA: Uncontrolled observational studies in patients with low back pain have reported some benefits from the use of facet joint radiofrequency denervation. Because the efficacy of percutaneous radiofrequency had not been clearly shown in previous studies, a randomized controlled trial was conducted to assess the efficacy of the technique for improving functional disabilities and reduce pain. METHODS: For this study, 70 patients with low back pain lasting of more than 3 months duration and a good response after intra-articular facet injections under fluoroscopy were assigned randomly to receive percutaneous radiofrequency articular facet denervation under fluoroscopic guidance or the same procedure without effective denervation (sham therapy). The primary outcomes were functional disabilities, as assessed by the Oswestry and Roland-Morris scales, and pain indicated on a visual analog scale. Secondary outcomes included spinal mobility and strength. RESULTS: At 4 weeks, the Roland-Morris score had improved by a mean of 8.4% in the neurotomy group and 2.2% in the placebo group, showing a treatment effect of 6.2% (P = 0.05). At 4 weeks, no significant treatment effect was reflected in the Oswestry score (0.6% change) or the visual analog pain score (4.2% change). At 12 weeks, neither functional disability, as assessed by the Roland-Morris scale (2.6% change) and Oswestry scale (1.9% change), nor the pain level, as assessed by the visual analog scale (-7.6% change), showed any treatment effect. CONCLUSIONS: Although radiofrequency facet joint denervation may provide some short-term improvement in functional disability among patients with chronic low back pain, the efficacy of this treatment has not been established.

4. Essentials of Pain Medicine and Regional Anesthesia, second edition published in 2005. Page 348-351 "Although facet joint injections are routinely used, no study to date has fulfilled following criteria: prospective, randomized, controlled with strict criteria and strict adherence to guidelines (e.g. restriction of other treatments) during the administration of the study.

-----

The physician providing this review is board certified in Anesthesiology and Pain Medicine. The reviewer has received additional certification from the American Academy of Pain Management. The reviewer has experience as a director of anesthesia, and pain management at hospital and sports clinic facilities. The reviewer has been in active practice since 1994.

Your Right To Appeal

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

Chief Clerk of Proceedings / Appeals Clerk  
P. O. Box 17787  
Austin, TX 78744

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute. MRIOA is forwarding this decision by mail, and in the case of time sensitive matters by facsimile, a copy of this finding to the DWC.

It is the policy of Medical Review Institute of America to keep the names of its reviewing physicians confidential. Accordingly, the identity of the reviewing physician will only be released as required by state or federal regulations. If release of the review to a third party, including an insured and/or provider, is necessary, all applicable state and federal regulations must be followed.

Medical Review Institute of America retains qualified independent physician reviewers and clinical advisors who perform peer case reviews as requested by MRIOA clients. These physician reviewers and clinical advisors are independent contractors who are credentialed in accordance with their particular specialties, the standards of the American Accreditation Health Care Commission (URAC), and/or other state and federal regulatory requirements.

The written opinions provided by MRIOA represent the opinions of the physician reviewers and clinical advisors who reviewed the case. These case review opinions are provided in good faith, based on the medical records and information submitted to MRIOA for review, the published scientific medical literature, and other relevant information such as that available through federal agencies, institutes and professional associations. Medical Review Institute of America assumes no liability for the opinions of its contracted physicians and/or clinician advisors. The health plan, organization or other party authorizing this case review agrees to hold MRIOA harmless for any and all claims which may arise as a result of this case review. The health plan, organization or other third party requesting or authorizing this review is responsible for policy interpretation and for the final determination made regarding coverage and/or eligibility for this case.

1204794.1

Case Analyst: Jamie C ext 583

CC: requestor and respondent