US Decisions Inc.

An Independent Review Organization
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Description of the service or services in dispute:
Intra-articular facet injections at L3-L4 and L4-L5 bilaterally

Description of the qualifications for each physician or other health care provider who reviewed the decision:

Board Certified Anesthesiologist

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

- ☑ Overturned (Disagree)
- ☐ Upheld (Agree)
- ☐ Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)

XXXX is a XXXX who was diagnosed with low back pain, lumbar region spondylosis with myelopathy, lumbar region spondylolisthesis, facet arthropathy and lumbar region intervertebral disc displacement.

The patient was evaluated by XXXX on XXX. The patient was injured on XXXX. The pain had started after an on-the-job XXXX. XXXX stated that XXXX pain started on the right side of XXXX low back and radiated to the left side of XXXX low back. XXXX denied radicular pain in the legs. The pain was increased with prolonged walking, standing, bending over, lifting, twisting and normal daily activities. The pain was decreased with ice therapy, healing therapy, relaxation and pain medications. XXXX had a done 13 physical therapy sessions, home exercises and tried over the counter nonsteroidal anti-inflammatory drugs (NSAIDs) with no alleviation of XXXX pain. XXXX took Tylenol-Codeine but stopped it when XXXX was prescribed Norco by XXXX for XXXX bilateral knee. On examination, there was tenderness to palpation to the lumbar paraspinal regions bilaterally. There was severe pain with extension of the lumbar spine. There was mild pain with flexion of the lumbar spine. The pain score was 8/10. The facet injections for bilateral L3-L4, L4-L5 and L5-S1 were requested.

A letter dated XXXX by XXXX indicated the patient had presented for the complaints of low back pain without radiculopathy into the bilateral lower extremities. XXXX rated the pain as 8/10. XXXX had completed 13 sessions of physical therapy, home exercises and had utilized over-the-counter nonsteroidal anti-inflammatory drugs, which had provided minimal pain relief. XXXX MRI findings had revealed a grade 1 anterolisthesis of L5 relative to S1, bilateral neural foraminal narrowing and bilateral facet arthropathy. Upon examination, tenderness to palpation of the bilateral lumbar paraspinal muscles with severe pain on lumbar extension and a decrease in pain with lumbar flexion were noted.

Treatment to date consisted of medications, ice therapy, heat therapy, relaxation therapy, physical therapy and home exercises.

An MRI scan of the lumbar spine performed on XXXX documented that at L2-L3, L3-L4, and L4-L5, there was a 2 mm broad annular bulge slightly effacing the thecal sac. At L5-S1, postsurgical changes of the right laminotomy were demonstrated.

An adverse determination letter dated XXXX by XXXX (Anesthesiology/Pain Management) indicated that the request for bilateral facet injections for L3-L4, L4-L5 and L5-S1 was denied. Based on the lack of non-operative treatment failure and the lack of the objective physical examination findings supporting the pathology, the request was not be warranted. The request for lumbar facet injections, arthrogram and fluoroscopy were not certified.

Per an adverse determination letter dated XXXX by XXXX (Pain Management), the reconsideration requests for facet injections for L3-L4, L4-L5 and L5-S1 bilateral, arthrogram and fluoroscopy were denied as they were not medically necessary.

An adverse determination letter dated XXXX, indicated that XXXX had non-authorized the medical necessity for bilateral facet injections at L3-L4 and L4-L5, arthrogram and fluoroscopy. The medical records provided for review showed that the patient had continued pain in the lower back. According to the guidelines, facet joint injections are not recommended due to a lack of supporting evidence supporting the efficacy of the procedure. Also, there was no evidence of failed conservative treatment to include the use of physical therapy to support the request. The request for facet injections at L3-L4 and L4-L5 bilaterally with arthrogram, fluoroscopy was not certified.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The findings of the prior reviews are not accurate. Firstly, the clinical findings suggest facet-mediated pain, in that there is a prominent axial component. This is indicative of irritation of the facet joints. Secondly, the MRI confirmed facet arthrosis and while some thecal indentation was noted, there is no major disc disease. Thirdly, conservative was attempted, including PT (13 sessions). Finally, only a two level injection was requested, not 3, as the reviews suggest.

The ODG were met and hence the procedure should be performed.

A description and the source of the screening criteria or other clinical basis used to make the decision:

ODG Treatment Integrated Treatment/Disability Duration Guidelines
Neck and Upper Back (Acute and Chronic) (updated 10/12/17)
<u>Facet joint therapeutic steroid injections</u>
Therapeutic intra-articular and medial branch blocks are Not Recommended by ODG. However, if the provider and payer agree to perform anyway, the following criteria should be met:
Clinical presentation should be consistent with facet joint pain, signs & symptoms.
1. There should be no evidence of radicular pain, spinal stenosis, or previous fusion.
2. If successful (initial pain relief of 70%, plus pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive).
3. When performing therapeutic blocks, no more than 2 levels may be blocked at any one time.
4. If prolonged evidence of effectiveness is obtained after at least one therapeutic block, there should be consideration of performing a radiofrequency neurotomy.

5. There should be evidence of a formal plan of rehabilitation in addition to facet joint injection therapy.
6. No more than one therapeutic intra-articular block is recommended.

Intra-articular blocks: No reports from quality studies regarding the effect of intra-articular steroid injections are currently known. There are also no comparative studies between intra-articular blocks and rhizotomy. (Falco, 2009) (van Eerd, 2010) There is one randomized controlled study evaluating the use of therapeutic intra-articular corticosteroid injections. The results showed that there was no significant difference between groups of patients (with a diagnosis of facet pain secondary to whiplash) that received corticosteroid vs. local anesthetic intra-articular blocks (median time to return of pain to 50%, 3 days and 3.5 days, respectively). (Barnsley, 1994)

Medial branch blocks: This procedure is generally considered a diagnostic block. There is one randomized controlled trial (RCT) comparing the effect of medial branch blocks with bupivacaine alone to blocks with the same local anesthetic plus steroid (60 patients in each group). No placebo arm was provided. Patients with radicular symptoms were excluded. Patients with uncontrolled major depression or psychiatric disorders and those with heavy opioid use were also excluded. Pain reduction per each individual block in both groups ranged from 14 to 16 weeks. It was opined that there was no role for steroid in the blocks, and the mechanism for the effect of local anesthetic only could only be speculated on. It was also noted that blocks were required 3 to 4 times a year for continued pain relief. (Manchikanti, 2008)

Complications: Low rates of infection, dural puncture, spinal cord trauma, spinal anesthesia, chemical meningitis, neural trauma, pneumothorax, radiation exposure, facet capsule rupture, hematoma formation and side effects of steroids. Fluoroscopy is recommended to avoid arterial, intrathecal, or spinal injection. (van Eerd, 2010) (Nelemans-Cochrane, 2000) (Manchikanti, 2004) (Manchikanti, 2003) (Boswell, 2007) (Falco, 2009) (Manchikanti, 2008) (Manchikanti, 2009a) (Carragee, 2009)

☐ ACOEM-America College of Occupational and Environmental Medicine um knowledgebase

☐ AHRQ-Agency for Healthcare Research and Quality Guidelines DWC-Division of Workers

☐ Compensation Policies and Guidelines European Guidelines for Management of Chronic Low Back Pain

☐ Interqual Criteria

☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical standards

☐ Mercy Center Consensus Conference Guidelines

☐ Milliman Care Guidelines

☑ ODG-Official Disability Guidelines and Treatment Guidelines

☐ Pressley Reed, the Medical Disability Advisor

☐ Texas Guidelines for Chiropractic Quality Assurance and 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)