

# P&S Network, Inc.

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## Notice of Independent Review Decision

**DATE OF REVIEW:** October 11, 2007

**IRO CASE #:**

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

This case was reviewed by a Pain Management Doctor, Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Bilateral L4-S1 facet medial nerve block

### **REVIEW OUTCOME**

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

Overtured- Disagree

### **REVIEW OF RECORDS**

- o Submitted medical records were reviewed in their entirety.
- o September 11, 2007 utilization review report
- o September 19, 2007 utilization review report
- o September 27, 2007 independent review organizations summary from Inc.
- o employers first report of injury or illness
- o August 9, 2007 notice and disputed issue from Inc.
- o Hospital medical records
- o request for medical care signed by the patient and an illegible physician signature
- o March 20, 2007 through June 11, 2007 work status reports by M.D.
- o March 20, 2007 through April 3 chart notes by M.D.
- o April 4, 2007 initial evaluation report by D.C.
- o April 4, 2007 through May 30, 2007 chiropractic records by D.C.
- o May 7, 2007 lumbar spine MRI report by M.D.
- o June 12, 2007 initial evaluation report by M.D.
- o June 26, 2007 functional capacity evaluation report by MOT, OTR
- o June 26, 2007 interval report by, M.D.
- o June 29, 2007 right shoulder MRI report by M.D.
- o July 9, 2007 through August 6, 2007 chart notes by M.D.
- o August 1, 2007 through August 22, 2007 chart notes from Rehabilitation
- o August 21, 2007 follow-up note by, M.D.
- o August 21, 2007 privileged and confidential report
- o September 6, 2007 chart notes from M.D.
- o September 10, 2007 chart notes by M.D.

### **CLINICAL HISTORY SUMMARY**

According to the medical records, the patient sustained an industrial injury involving the lumbar spine. A request was made for bilateral L4-S1 facet medial nerve blocks. The request was first reviewed and a non-certification was rendered. The rationale provided was that the patient is months from the date of injury with

unremarkable lumbar imaging. There was no consistent clinical presentation will over six months of serial examinations to suspect facet-mediated pathology according to the reviewer. The Official Disability Guidelines were cited as indicating that facet injections are not efficacious beyond placebo.

The case was again reviewed on September 19, 2007 by another physician reviewer. A non-certification was rendered at that time based on the Official Disability Guidelines and a statement that the patient's current primary complaints include right upper quadrant abdominal pain. The patient was noted to have lower lumbar bilateral complaints of pain, however physical examination was said to be unremarkable with a negative lumbar MRI.

In reviewing the medical records, the patient reportedly was working when he began having back pain after doing heavy lifting in the warehouse. He reported it, but there was no action taken. For three weeks he stated that he struggled at work, lifting heavy loads, except that he was using other muscles to compensate which caused him to have torso and shoulder pain.

A May 7, 2007 lumbar spine MRI report was submitted for review. The report fails to document any positive findings and was interpreted as entirely normal. The patient has reportedly undergone treatment with multiple medications, chiropractic care, neuromuscular stimulation, and a portable whirlpool.

An August 21, 2007 report states that the patient's back continues to hurt at an 8/10 level. Examination findings included tenderness in the lumbar spine that radiates upwards and downwards but not into the legs, no tenderness in the sacroiliac joints, and a notation that the examination produces much less tenderness than at the initial evaluation. The report notes that the patient seems to have reached a point where he is no longer getting better.

The most recent chart notes, dated September 6, 2007, states that the patient's primary complaint is abdominal pain. However he complains of low back pain that is at a 7/10 with pain medication. The location of the pain is noted to be primarily in the lower lumbar spine radiating into the mid/upper back. He characterizes it as constant, severe, and throbbing. The pain worsens with sitting and he is able to sleep on his side, with his knees drawn up. Examination findings included full active range of motion with extension and flexion, no pain elicited to palpation, normal sensation, symmetric deep tendon reflexes, normal motor strength, bilateral positive Kemp's, positive slump, positive bilateral straight leg raise, negative bilateral Gaenslen's sign, and the positive slump and straight leg raise are positive for back pain only. Regarding the abdominal pain, he was assessed with right upper quadrant abdominal pain as the examination did not reveal any abnormality. The physician stated that there was a small chance that he may have fractured a rib during his injury, but nothing could be done about this. He assessed the patient with an exam highly suggestive of lumbar spondylarthritis and L4-S1 facet median nerve blocks were recommended.

#### **ANALYSIS AND EXPLANATION OF DECISION**

According to the Official Disability Guidelines, facet joint medial branch blocks are not recommended except as a diagnostic tool in assisting to see if the patient will benefit from neurotomy procedures. The section for medial branch blocks in the guidelines refers the reader to the facet joint diagnostic block section for criteria regarding medial branch blocks for diagnostic purposes. The criteria state that the blocks should be limited to patients with low back pain that is non-radicular and at no more than two levels bilaterally. There should be documentation of failure of conservative treatment prior to the procedure for at least 4-6 weeks.

The most recent examination has found the patient to be neurologically intact in the lower extremities regarding motor strength, sensation, and deep tendon reflexes. Straight leg raise and other orthopedic tests produce back pain only and not radiating leg pain. The medical records reflect that the patient has undergone extensive conservative management that has failed to produce lasting relief. The guidelines further state that there are no findings on history, physical or imaging studies that consistently aid in making this diagnosis. Thus, the negative imaging study does not necessarily exclude the patient from diagnostic medial branch blocks.

Given that the patient has undergone conservative management for several months without resolution of symptoms, I agree with the requesting physician that pursuing medial branch blocks is appropriate. However, these should be done diagnostically, as they are not supported by the medical literature for therapeutic purposes. Therefore, I recommend to overturn the decision to non-certify bilateral L4-S1 medial nerve blocks, to certify diagnostic bilateral L4-S1 medial nerve blocks.

The IRO's decision is consistent with the following guidelines:

#### **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

Official Disability Guidelines (2007) Facet joint medial branch blocks (therapeutic injections):

Not recommended except as a diagnostic tool. Therapeutic facet blocks use a local anesthetic and are intended to have an on-going therapeutic effect as they numb the source of pain. There has been only one study that supports medial branch blocks in a therapeutic capacity. Patients either received a local anesthetic or a local anesthetic with methyl prednisolone. (Manchikanti, 2001) All blocks included Sarapin. Sixty percent of the patients overall underwent seven or more procedures over the 2 ½ year study period ( $8.4 \pm 0.31$  over 13 to 32 months). There were more procedures recorded for the group that received corticosteroids than those that did not (301 vs. 210, respectively). Based on this study, certain guidelines have suggested that medial branch blocks show moderate evidence for treatment of chronic lumbar spinal pain. (Boswell, 2005) [Moderate evidence is defined as "further research is likely to have an important impact on confidence of estimating the effect of treatment and likely to change the estimate," per Grade Working Group. (Atkins, 2004)] The use of the blocks for diagnostic purposes is discussed in Facet joint diagnostic blocks (injections). See also Facet joint intra-articular injections (therapeutic blocks).

Official Disability Guidelines (2007) Facet joint diagnostic blocks (injections):

Recommended prior to facet neurotomy (a procedure that is considered "under study"). Diagnostic blocks can either be an intra-articular facet joint block, or a medial branch block, with the diagnosis based on pain relief after the injection. Due to the high rate of false positives with a single block, confirmatory blocks are suggested, and at least one diagnostic block should be a medial branch block. Diagnostic blocks are performed with the anticipation that if successful, treatment may proceed to facet neurotomy at the diagnosed levels. The technique for medial branch blocks in the lumbar region is the following: (1) L1-L2, L2-L3, L3-L4, L4-L5: requires a block of 2 medial branch nerves (i.e. at L4-5, the L3 and L4 nerves are blocked at the transverse processes of L4 and L5); (2) L5-S1: L4 and L5 are blocked as above, and it is recommended that S1 be blocked at the superior articular process. (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. (Washington, 2005) (Manchikanti, 2003) (Dreyfuss, 2003) (BlueCross BlueShield, 2004) (Pneumatics, 2006) 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:

1. Limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally.
2. There is documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks.
3. No more than 2 joint levels are injected in one session (see above for medial branch block levels)
4. A minimum of 2 diagnostic blocks per level are required, with at least one block being a medial branch block.
5. 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.
6. Opioids should not be given as a "sedative" during the procedure
7. The use of IV sedation may be grounds to negate the results of a diagnostic block, and should only be given in cases of extreme anxiety
8. A response of ? 70% pain relief for the duration of the anesthetic used is required in order to progress to the second diagnostic block (approximately 2 hours for Lidocaine).
9. The diagnosis is confirmed with documentation of ? 70% pain relief with both blocks.
10. 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.
11. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated. (Resnick, 2005)
12. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level.
13. Bilateral blocks are generally not medically necessary.