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Notice of Independent Review Decision

DATE OF REVIEW: 05/20/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Item in dispute: ACS Services

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

Board Certified in Physical Medicine & Rehabilitation
Fellowship Trained in Pain Management

REVIEW OUTCOME

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

Denial Overturned

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is female who was reported to have low back pain as a result of a work place event. The employee is currently under the care of Dr..

The first available medical record is a radiographic report dated 01/21/08. This study reported facet screws at L4-L5 and L5-S1 with intervertebral disc plugs at the same levels. It was felt that there may be lucency about the screws at L4-L5 although there was no evidence of obvious lucency about the disc cage. This lucency could reflect motion, and if warranted, flexion/extension views or CT might be a consideration for further evaluation. This was otherwise an unremarkable examination. Small spurs were seen in the upper lumbar region. This study reported evidence of anterior posterior fusion at L4-L5 and L5-S1 with an equivocal finding of a loose screw on the left at L4-L5.

The employee was seen by Dr. on 03/11/08. The employee had complaints of

pain in her low back and in the anterior posterior aspects of her right leg. She also had pain in the medial lateral thigh and groin regions, which was worse on the right side than the left side. It was noted that the employee had problems dating back to her injury in xxxx. She was status post lumbar fusion. She has maintained pain control post this procedure with intermittent nerve blocks, oral medications, and self-directed therapy. The employee had been experiencing a progressive increase in her pain over the past multiple months. She had been experiencing difficulty during ambulating and stretching exercises secondary to this. She has an aggravation of pain if she sits for extended periods of time, prolonged standing, and with the supine position. She rated her pain as 9/10 on a pain scale. The employee's pain level had been down to 2/10 or 3/10 with ongoing treatment. It was noted the employee had not sustained any new or recent trauma. The employee did not report any changes in bowel or bladder control. There was some stiffness associated with her pain, which was worse in the morning. The employee continued to experience numbness and tingling sensation in her right buttock. An MRI scan was reported to have been performed on 09/13/06, which revealed L2-L3 posterior element hypertrophy, L3-L4 posterior element hypertrophy, L5-S1 posterior element hypertrophy, and L5-S1 anterolisthesis. A thoracic MRI was reported to be normal. Radiographs from 01/21/08 revealed a posterior fusion at L4-L5 with a loose screw on the left at L4-L5. On physical examination, the employee ambulated into the examination room without difficulty or assistive devices. She was well developed and well nourished. Upon examination of the neck, the employee had full cervical range of motion. Motor function was normal in the upper extremities. The employee had full range of motion of the shoulder, elbow, and wrist joints. Sensory examination was normal in the bilateral upper extremities. The employee had 2+ and symmetrical reflexes in the upper extremities. On examination of the lumbar spine the employee has lumbosacral tenderness to palpation. A lumbosacral scar was noted. Lumbar range of motion was reduced. Straight leg raising was positive for low back pain and posterior thigh pain. She had significant tenderness to palpation of the lumbosacral facets. Reflexes were 2+ and symmetric at the patella and Achilles. There was decreased sensation in the lateral aspect of the right leg. Motor function was normal in the lower extremities musculature. There was tenderness to palpation at the right posterior superior iliac crest. The employee was diagnosed with lumbar disc disease and lumbar radicular pain. This component had been increasing. The employee needed to have epidural steroid treatments for this. She had lumbar facet arthrosis at the L3-L4 level. She would benefit from facet median branch blocks at L2 and L3 to cover this area. If she obtained relief, but temporary, then radiofrequency lesioning could be performed for more prolonged relief. The employee continues to experience problems. She is an excellent candidate for spinal cord stimulation. There is a question of loosening of some of her hardware, and she may benefit from actually having hardware removed. She is continued on oral medications. She has previously undergone an Independent Medical Evaluation (IME) by Dr. who recommended that she be taken off her medications and tried with Neurontin and possibly Elavil.

The employee was seen in follow-up on 04/03/08. Her history was unchanged and the physical examination remained unchanged. Dr. reported that the employee has facet arthrosis, specifically at L2-L3 and L3-L4. Her back pain and thigh pain was consistent with this as a source of pain. She has pain with sitting and with position. She had painful decreased lumbar extension and had tenderness to palpation over the facets. Therefore, it was felt the employee would benefit most likely from having treatment in this area. She had additional sources of pain, and this was radicular type associated with her degenerative disc disease at L4-L5 and L5-S1. She has a loosening of hardware in this area. Therefore, the employee would benefit from epidural steroid injections.

On 03/12/08, a request was placed for medial branch blocks. This was reviewed on 03/17/08 by Dr. Dr. reported that there was no evidence that the facets were the cause of the employee's pain and noted the fusion had not rid the employee of back pain in the past. Of the two levels that were requested. perhaps one of the levels is fixed. A peer-to-peer contact was made, and Dr. indicated that no additional information was provided and did not certify the request.

A request for reconsideration was submitted on 03/12/08 and was subsequently reviewed by Dr. who issued an opinion on 04/10/08. Dr. did not certify the request and opined that Dr. had recommended epidural steroid injection for the radicular pain along with facet medial branch blocks at L2 and L3 to cover the lumbar facet arthrosis. If this offered relief, Dr. recommended RFTC. Dr. Obermiller reported the **Official Disability Guidelines** clearly states that facet blocks are limited to employees with low back pain that is not radicular. This claimant has clear physical findings of radiculopathy, which would not meet the **Official Disability Guidelines**, and therefore, he did not certify the request.

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

I would not concur with the previous reviewers. Based on the submitted medical information, the employee is status post an anterior and posterior lumbar interbody fusion at L4-L5 and L5-S1. The available imaging studies indicate that the employee clearly has evidence of facet arthrosis at L2-L3 and L3-L4. The employee subsequently has two ongoing conditions which are separate. The employee has evidence of a lumbar radiculopathy as a possible residual from her previous two level fusion and clear evidence of facet arthrosis at L2-L3 and L3-L4. The employee's physical examination is consistent with these findings.

Dr. has requested to perform medial branch blocks at L2 and L3, which would be consistent with both the radiographic imaging and the employee's physical examination. The radicular complaints are secondary to the employee's previous anterior and posterior lumbar interbody fusion and are clearly unrelated to the documented symptomatic facet disease.

Given this information, the requested procedure of medial branch blocks at L2 and L3 is considered medically necessary and appropriate and supported by the **Official Disability Guidelines** and current evidence-based guidelines.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

1. The **Official Disability Guidelines**, 11th Edition, The Work Loss Data Institute.
2. Laxmaiah Manchikanti, MD, Vijay Singh, MD, David Kloth, MD, Curtis W. Slipman, MD, Joseph F. Jasper, MD, Andrea M. Trescot, MD, Kenneth G. Varley, MD, Sairam L. Atluri, MD, Carlos Giron, MD, Mary Jo Curran, MD, Jose Rivera, MD, A. Ghafoor Baha, MD, Cyrus E. Bakhit, MD and Merrill W. Reuter, MD. **American Society of Interventional Pain Physicians Practice Guidelines**. *Pain Physician*, Volume 4, Number 1, pp 24-98, 2001.