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Notice of Independent Review Decision

DATE OF REVIEW: June 9, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Facet joint medial branch blocks at L4-S1.

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

Fellow American Academy of Physical Medicine and Rehabilitation

REVIEW OUTCOME

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

X Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who developed low back pain when he along with his coworkers was lifting the bar to replace the wheels underneath.

X-rays of the lumbar spine obtained were unremarkable. Magnetic resonance imaging (MRI) of the lumbar spine revealed at the L2-L3 level, a very mild 1-mm generalized disc bulge; and at the L3-L4 level, mild anterior endplate spurring. On July 16, 2008, M.D., evaluated the patient for bilateral lower extremity pain, right greater than left and low back pain. He noted that the patient was sent to the company doctor at the following day, where he was provided with medications and placed on work restrictions. Three days post injury, he was provided with an injection to the buttocks bilaterally and his lower extremities became symptomatic since that time. He had 10 sessions of passive therapy with the company doctor and one month of work conditioning program (WCP) with little benefit. He also underwent another injection to the right buttock in February 2008, with 50 to 60% relief for one month. Examination revealed paraspinal spasms bilaterally on lateral bending, left greater than right; positive extension and rotation bilaterally left greater than right with pain in the low back ipsilateral to the side of rotation; mild tenderness bilaterally at lower lumbar segments; positive straight leg raise (SLR) with pain in the right inguinal region; hyperesthesias in the dermatomal pattern along the medial aspect of the left foot and great toe (L4 nerve root distribution). Dr. assessed lumbar radicular syndrome and recommended diagnostic caudal epidural steroid injection (ESI). From July through December, the patient had chiropractic care with D.C.

Electromyography/nerve conduction velocity (EMG/NCV) revealed absent bilateral posterior tibial H-reflex response suggestive of S1 radiculopathy.

Dr. obtained lumbar matrix scan which revealed potential surgical disc on the right at L4-L5.

Lumbar myelogram revealed mild anterior extradural defects at L2-L3 and markedly limited range of motion (ROM) with lumbar flexion and extension, likely from surrounding paraspinal levels. Dr. recommended caudal ESI but the patient did not want to proceed and therefore he was referred to chronic pain management program (CPMP).

2009: In March, Dr. noted pain score rated at 6-9/10 with limited functional tolerances. He reviewed the report of a designated doctor evaluation (DDE) performed by M.D., on January 22, 2009, who recommended the patient to undergo an ESI and follow-up with a spine surgeon. The report also disclosed that the patient was not at MMI as of date of the exam but may be at MMI on or about April 21, 2009. The patient had 10 days of CPMP with Dr. The patient reported that he was assigned 5% whole person impairment (WPI) rating in May 2008. His ongoing medications included Tylenol ES. Dr. recommended proceeding with caudal ESI.

Caudal ESI was performed but the patient continued to experience prominent low back pain and bilateral leg pain left more than the right, and pain from low back to toes second and third on each foot.

Lumbar MRI was performed that revealed minimal disc desiccation from L2-L3 through L4-L5 and anterior fatty L3-L4 and left edematous L2-L3 endplate degenerative changes, minimal disc bulge at L2-L3.

On April 13, 2009, the patient reported low back pain at 4-8/10 with tightness, pressure, and numbness in the low back after being supine for 10 minutes or more and bilateral lower extremity pain left more than right, 6-7/10 described as pressure from low back to the base of the toes second and third on the left leg, and to the ankle in the right leg. Dr. noted continuation of CPMP with Dr. was denied by the carrier. Dr. recommended medial branch blocks at L4-L5 and L5-S1 facets bilaterally to help ascertain if patient is a candidate for radiofrequency rhizolysis.

On April 17, 2009, M.D., non-authorized the request for medial branch block of L4-L5 and L5-S1 facet bilaterally with the following rationale: *The documentation presented has previously qualified the patient for ESI which required radicular confirmed pathology and exam by this provider. Now the patient has documentation of facet and paravertebral documentation reported by the same provider and of note continues to have positive SLR's which as per the ODG is an excluding physical finding for the requested procedure as noted in the above cited guideline. Therefore the adverse determination has been rendered with regard to the requested procedure.*

On May 1, 2009, reconsideration review was denied by M.D., with the following rationale: *The presence of radicular symptoms and the suggestion that "diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated". It appears that the original denial of the request to pre-authorize the medial facet nerve blocks was appropriate and should be upheld.*

From January through May, the patient continued to get chiropractic care by Dr.

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

Patient has radicular signs and surgery is anticipated, both are contraindications to diagnostic facet blocks per ODG and standard of care. Therefore, it is this reviewer's opinion that the decision should be upheld.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES