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DATE OF REVIEW: 05/16/09

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 (Board Certified), 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

Lumbar medial branch block L3-5

REVIEW OUTCOME

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

(Upheld) (Agree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- o Submitted medical records were reviewed in their entirety.
- o Treatment guidelines were provided to the IRO.
- o October 1, 2004 Lumbar MRI read by Dr.
- o April 22, 2005 Operative report from Dr.
- o April 13, 2006 Operative report from Dr.
- o April 20, 2006 Operative report from Dr.
- o April 27, 2006 Follow-up Consultation and Exam from Dr.
- o May 3, 2007 Operative report from Dr.
- o May 22, 2006 Follow-up Consultation and Exam from Dr.
- o May 17, 2007 Operative report from Dr.
- o May 30, 2007 Follow-up Consultation and Exam from Dr.
- o August 6, 2007 Follow-up Consultation and Exam from Dr.
- o October 11, 2007 Operative report for MMB from Dr.
- o October 17, 2007 Follow-up Consultation and Exam from Dr.
- o March 27, 2008 Operative report for RFA from Dr.
- o April 16, 2008 Follow-up Consultation and Exam from Dr.
- o October 7, 2008 Follow-up Consultation and Exam from Dr.
- o November 12, 2008 Follow-up Consultation and Exam from Dr.
- o November 24, 2008 Lumbar MRI interpreted by Dr.
- o December 1, 2008 Follow-up Consultation and Exam from Dr.
- o January 5, 2009 Psyche Assessment from Dr.
- o March 16, 2009 Follow-up Consultation and Exam from Dr.
- o April 7, 2009 Medical evaluation report from Dr.
- o April 13, 2009 Follow-up Consultation and Exam from Dr.
- o April 21, 2009 Utilization Review findings re LMMB L3-5 from
- o May 1, 2009 Utilization Review findings re reconsideration for LMMB from
- o May 5, 2009 Request for IRO from Dr.
- o May 6, 2009 IRO assignment

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews the patient is a employee who sustained an industrial injury to the low back in

xxxx associated with lifting. She is status post right hemilaminotomy and discectomy L4-5 on April 22, 2005 which she does not feel was helpful. She has been managed by her current provider since 2006. The patient underwent left L3-S1 medial/lateral branch blocks on April 13, 2006, left L3-S1 medial/lateral branch blocks on April 20, 2006, right L3-S1 medial/lateral branch blocks on May 3, 2007, right L3-S1 medial/lateral branch blocks on May 17, 2007, right L3-S1 radiofrequency ablation on July 17, 2007, left medial branch block on October 11, 2007 and right medial branch neurotomy L5-S1 on March 27, 2008 with 7 months of relief. Per her primary provider, the current diagnosis is L4-5 radiculopathy, status post laminectomy/discectomy and lumbar facet syndrome.

Lumbar MRI of October 2004 showed no visible canal or nerve root compromise.

The progress report of April 27, 2006 indicates the patient reports only 20% improvement with the medial branch blocks administered on April 20, 2006. The relief lasted only 2-3 days. She states the Marcaine blocks provide longer relief. On May 22, 2006 the patient reported the left MBBs provided 70% reduction in her pain. The Marcaine blocks provided less than a day of relief. The lidocaine blocks provided longer relief. Since the lidocaine blocks provided longer relief, we will not proceed with lumbar radiofrequency neurotomy.

On May 30, 2007 the patient reported 75-80% improvement with right medial/lateral branch blocks that lasted less than 3 days. She feels the Marcaine blocks helped her more than the lidocaine blocks. The Marcaine blocks provided 5 days of relief. She appears to have facet mediated pain and we will proceed with right L3-S1 radiofrequency neurotomy.

The progress report of August 8, 2007 notes the patient is 80% better with the radiofrequency ablation procedure of July 17, 2007. She was advised to taper her narcotics.

The progress report of October 17, 2007 states the patient is status post left L3-S1 medial branch blocks on October 11, 2007. She states that it flared up her pain. She states the pain subsided after a few days. However, it didn't help her. In fact it flared up her pain. A Toradol injection was provided.

On April 16, 2008 the patient is noted to be status post right L3-S1 radiofrequency ablation with 80% improvement noted. She still has some residual low back pain and left sided hip and buttock pain. She is taking Ultram and Eleve as needed for pain. Her residual pain may be a combination of discogenic and post-surgical pain.

The medical report of October 7, 2008 notes the patient was provided a Toradol injection and placed on Norco.

The medical report of December 1, 2008 reviews a recent lumbar MRI of November 24, 2008 which shows disc dessication at L4-5, L5-S1 with prior laminectomy noted, No residual stenosis detected. Central small disc protrusion L5-S1. No definite foraminal compromise is seen. This study is relatively stable from the previous exam in 2005. She continues to have significant intermittent low back pain. Options were discussed of lumbar discogram with a possible 2-level fusion or trial of spinal cord stimulation.

According to a Psychological Assessment of January 5, 2009 the patient has a history of hypothyroidism. She is using medication of Lortab. She reports primarily low back pain that radiates down the right lower extremity with associated numbness and tingling. Her average pain level is 3-4/10. The patient was cleared psychologically for trial of a spinal cord stimulator.

Per a neurosurgical examination of April 7, 2009 the patient has been considering a discogram and possible fusion versus a trial of spinal cord stimulation. She has primarily low back pain. Sitting is more painful than standing and lying down is the least painful. She has some pain referred into the left buttock and upper thigh with very occasional pain in the right L4-5 distribution to the calf. She rates her pain as ranging from 4-10/10. She reports numbness in the bilateral first through third toes. She has pins and needles sensations in the low back and has a sense of weakness in her low back on arising which she believes in pain related. She has not had neurodiagnostics. She continues to work 4 hours a day as in-home support. She is 5' 2" and 202 pounds. There is tenderness over the bilateral facets, SI joints and bilateral PSIS. Range of motion is restricted and painful. Motor strength is full but sensation is diminished in the L4 distribution. Straight leg raise is negative. Her current symptoms appear to be lumbar facet and SI joint in origin. Her current diagnosis is, chronic pain syndrome, lumbar postlaminectomy syndrome, radicular syndrome of the lower limbs, degenerative disc disease lumbosacral, lumbar intervertebral disc displacement without myelopathy, lumbar spondylosis without myelopathy and long-term use of high-risk medications. She may be a candidate for SCS trial in lieu of provocation discogram and fusion. However, recommendation is for repeat diagnostic lumbar medial branch blocks with neurotomy if positive, as well as SI joint injections with denervation if positive.

Request for lumbar medial branch block L3-5 was not certified in review on April 21, 2009 based on review of 4 pages of medical records with rationale that the intervention failed to meet the ODG criteria. A peer discussion was attempted but not realized. The ODG criteria include, one set of diagnostic medial branch blocks is required with a response of 70%. The pain response should be approximately 2 hours for Lidocaine. Limited to patients that is non-radicular and at no more than two levels bilaterally. The patient should document pain relief with an instrument such as a VAS scale. The medical records indicated the patient has radicular pain and the medical records failed to document exhaustion of conservative treatments.

Request for reconsideration of lumbar medial branch blocks L3-5 was not certified in review based on 43 pages of records on May 1, 2009 following several attempts of peer discussion with rationale that the medical records document radiculopathy and the clinician is requesting blocks at three levels while guidelines recommend only two levels.

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

Per ODG, recommendation is for no more than one set of medial branch blocks prior to facet neurotomy. The patient has been provided two sets of medial branch blocks in 2006 and three sets in 2007. Additional medial branch blocks would not be supported by guidelines.

Per ODG, medial branch blocks should be limited to patients with low-back pain that is non-radicular. While lumbar MRI of October 2004 showed no visible canal or nerve root compromise and the December 2008 MRI shows no definite foraminal compromise, the patient's diagnosis includes L4-5 radiculopathy. In April 2008, the provider noted, her residual pain may be a combination of discogenic and post-surgical pain. The examiner of January 2009 noted, primarily low back pain that radiates down the right lower extremity with associated numbness and tingling. The neurosurgical examination of April 2009 noted, some pain referred into the left buttock and upper thigh with very occasional pain in the right L4-5 distribution to the calf. She reports numbness in the bilateral first through third toes. Motor strength is full but sensation is diminished in the L4 distribution. The neurosurgical diagnosis includes, radicular syndrome of the lower limbs.

Therefore, my determination is to agree with the previous non-certification of the request for lumbar medial branch block L3-5.

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

The Official Disability Guidelines, Lumbar, Facet Joint Diagnostic Blocks (5-11-2009):

Recommend no more than one set of medial branch diagnostic blocks prior to facet neurotomy, if neurotomy is chosen as an option for treatment (a procedure that is still considered "under study"). Diagnostic blocks may be performed with the anticipation that if successful, treatment may proceed to facet neurotomy at the diagnosed levels. Current research indicates that a minimum of one diagnostic block be performed prior to a neurotomy, and that this be a medial branch block (MBB). Although it is suggested that MBBs and intra-articular blocks appear to provide comparable diagnostic information, the results of placebo-controlled trials of neurotomy found better predictive effect with diagnostic MBBs. In addition, the same nerves are tested with the MBB as are treated with the neurotomy. The use of a confirmatory block has been strongly suggested due to the high rate of false positives with single blocks (range of 25% to 40%) but this does not appear to be cost effective or to prevent the incidence of false positive response to the neurotomy procedure itself. (Cohen, 2007) (Bogduk, 2000) (Cohen2, 2007) (Mancchukonda, 2007) (Dreyfuss, 2000) (Manchikanti2, 2003)

Etiology of false positive blocks: Placebo response (18-32%), use of sedation, liberal use of local anesthetic, and spread of injectate to other pain generators. The concomitant use of sedative during the block can also interfere with an accurate diagnosis. (Cohen, 2007)

MBB procedure: The technique for medial branch blocks in the lumbar region requires a block of 2 medial branch nerves (MBN). The recommendation is the following: (1) L1-L2 (T12 and L1 MBN); (2) L2-L3 (L1 and L2 MBN); (3) L3-L4 (L2 and L3 MBN); (4) L4-L5 (L3 and L4 MBN); (5) L5-S1: the L4 and L5 MBN are blocked, and it is recommended that S1 nerve be blocked at the superior articular process. Blocking two joints such as L3-4 and L4-5 will require blocks of three nerves (L2, L3 and L4). Blocking L4-5 and L5-S1 will require blocks of L3, L4, L5 with the option of blocking S1. (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. Specifically, the concern is that the lateral and intermediate branches will be blocked; nerves that innervate the paraspinal muscles and fascia, ligaments, sacroiliac joints and skin. (Cohen, 2007) Intraarticular blocks also have limitations due to the fact that they can be technically challenging, and if the joint capsule ruptures, injectate may diffuse to the epidural space, intervertebral foramen, ligamentum flavum and paraspinal musculature. (Cohen, 2007) (Washington, 2005) (Manchikanti, 2003) (Dreyfuss, 2003) (BlueCross BlueShield, 2004) (Pneumatics, 2006) (Boswell, 2007) (Boswell2, 2007) A recent meta-analysis concluded that there is insufficient evidence to evaluate validity or utility of diagnostic selective nerve root block, intra-articular facet joint block, medial branch block, or sacroiliac joint block as diagnostic procedures for low back pain with or without radiculopathy. (Chou2, 2009) 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:

Clinical presentation should be consistent with facet joint pain, signs & symptoms.

1. One set of diagnostic medial branch blocks is required with a response of = 70%. The pain response should be approximately 2 hours for Lidocaine.
2. Limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally.
3. There is documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks.
4. No more than 2 facet joint levels are injected in one session (see above for medial branch block levels).
5. Recommended volume of no more than 0.5 cc of injectate is given to each joint.
6. 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.
7. Opioids should not be given as a "sedative" during the procedure.
8. The use of IV sedation (including other agents such as midazolam) may be grounds to negate the results of a diagnostic block, and should only be given in cases of extreme anxiety.
9. 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.
10. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated. (Resnick, 2005)
11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level