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Notice of Independent Review Decision

MEDICAL RECORD REVIEW:

DATE OF REVIEW: 05/04/2010

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) 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

Left L4-5, L5-S1 medial branch block (New CPT codes are 64493, 64494, 64495)

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

- Submitted medical records were reviewed in their entirety.
- Treatment guidelines were provided to the IRO.
- 08-30-04 through 11-21-06 follow-up consultations from
- 02-23-06 Operative Report for bilateral L4-5 and L5-S1 intra-articular blockade from
- 10-19-06 Operative Report for L4-S1 medial branch blockade from
- 11-09-06 Operative Report for right L4-S2 medial branch rhizotomies from
- 05-30-07 Operative report for right L4-5 blockade from
- 07-23-07 Follow-up Consultation from
- 08-09-07 Operative report for lumbar epidural steroid injection right L4, L5 from
- 02-26-08 Prescription/Order for Back Brace from Medical
- 02-26-08 Follow-up Consultation from
- 03-27-08 Operative Report for left L4-S1 median branch blockade from
- 04-01-08 Follow-up Consultation from
- 04-17-08 Operative Report for bilateral rhizotomy L4-S1 from
- 04-29-08 Follow-up Consultation from
- 10-07-08 Follow-up Consultation from
- 10-16-08 Fax request for preauthorization bilateral MBB L4-S1 from
- 10-31-08 Follow-up Consultation from
- 12-22-08 Operative Report for left L4-S1 medial branch blockade from
- 01-20-09 Follow-up Consultation from
- 02-09-09 Operative Report for left rhizotomy L4-S1 from
- 02-24-09 Follow-up Consultation report from
- 07-21-09 Follow-up Consultation report from
- 01-05-10 Follow-up Consultation from

- 01-28-10 Fax request for left L4, 5, S1 median branch block from
- 03-09-10 Follow-up Consultation from
- 03-17-10 Fax request for left L4-S1 MMB from
- 03-19-10 Adverse Determination letter from xxxxx
- 04-06-10 Adverse Determination letter for reconsideration from xxxx
- 04-19-10 Request for IRO from the Claimant
- 04-19-10 Confirmation of Receipt for Request for IRO from TDI
- 04-19-10 Notice of Case Assignment of IRO from TD

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews the patient is male employee of a hospital (age not stated) who sustained an industrial injury to the low back. He is followed with a diagnosis of lumbar post-laminectomy syndrome, lumbosacral spondylosis without myelopathy, sacroiliitis and lumbosacral neuritis.

According to the medical report of xxxxx the patient was seen status post bilateral L4-S1 medial nerve blocks and denervation to the bilateral medial branch nerves at L4-5 as well as a confirmatory right L4-5 selective nerve root block, which reduced his pain level from 8/10 to 5/10 and improved the radicular elements of his lumbar syndrome. He desires additional treatments for both the band-like pain across his SI, as well as the radicular symptoms over the L4-5 distribution. On examination, straight leg raise is positive; nerve root stretch signs are negative. Diagnosis is post-laminectomy syndrome, lumbar radiculopathy and sacroiliitis. Recommendation was for a second in a possible series of three epidural injections to be performed below the level of his surgery.

The patient underwent a second right L4, L5 lumbar epidural steroid injection on August 9, 2007.

The patient was reevaluated on October 7, 2008. He was last seen April 29, 2008. He has done well with denervation rhizotomy in the past, but has had a number of falls recently that may be associated with other potential side effects that have caused him to aggravate his low back pain and re-trigger some of the mechanical pain to extension tilt rotation and direct palpation over the L3 to S1 distribution. He has undergone bilateral L4-S1 MMB followed by RFTC, removal of spinal cord stimulator after revision of IPG due to infection and then replacement (on 8/04) and has had medical management and SCS placed previously, which have worked well long term. His current pain level is 8/10. Sensation is decreased, right greater than left, at L4-5. Motor strength is 3/5, right greater than left, in the L4-5 distribution. Recommendation is for follow-up diagnostic medial branch block.

On October 16, 2008 request was made to perform bilateral L4-S1 medial branch blocks for a diagnosis of lumbar facet syndrome.

The patient was reevaluated on January 20, 2009. He was last seen October 31, 2008 at which time he underwent left L4, L5 and S1 medial branch block, which confirmed both prognostically and diagnostically the source of his pain symptomatology over the left lower facet and spondylosis region. He previously underwent radiofrequency ablation with excellent, long lasting response. He has cardiac issues, which are being followed. He is stable with medications and a pacemaker. He had no difficulty being off Plavix and aspirin prior to the medial branch block. There is long standing hypoesthesia, right greater than left, in the L4,5 distribution and longstanding right L4,5 motor weakness. Recommendation is for follow-up rhizotomy.

The patient underwent left L4-S1 rhizotomy on February 9, 2009. He was seen in follow-up on February 24, 2009 and reported benefit with the procedures. He is back on his Plavix and aspirin. A pain level is not reported. The examination remains unchanged. He is anticipated to benefit from the rhizotomy for 6-9 months.

The patient was reevaluated on July 21, 2009. He was last seen on February 24, 2009. He is still tolerating his back pain well since the rhizotomies of February 2009. He reports a pain level of 7/10. He will continue use of the TENS unit and Lidoderm patches.

The patient was reevaluated on January 5, 2010. His symptoms have returned involving his left hip and he is reporting a pain level of 8-10/10. He responded well to rhizotomy L4-S1 on February 9, 2009. He is xxxx and xxxxx pounds. He has residual tenderness over the known topical psoriasis and provocation over his SI area, left greater than right. Straight leg raise is positive; root tension sign is negative. There is sensation and motor weakness as previously reported. He has not undergone any facet procedures since February due his use of Plavix and Coumadin. His anti-coagulation provider will be queried to see if he can be off the Coumadin for at least 7 days to consider follow-up medial branch block and/or denervation rhizotomy and to see if he can be off Plavix as well.

On January 28, 2010 request was made for left L4, 5, S1 medial branch blocks for a diagnosis of lumbar facet syndrome.

The patient was reevaluated on March 9, 2010. His cardiologist has approved him to be off Coumadin for one week and Plavix for two weeks prior to performing a diagnostic left L4,5, S1 medial branch blocks. Sensation and motor strength are abnormal as previously reported. He is given a back brace. He is recommended to undergo repeat medial branch blocks. If blocks are positive, he will need to go off the Coumadin and Plavix also for the rhizotomy procedure.

Request for lumbar medial branch blocks at left L4-5, L5-S1 (repeat facet joint medial branch block) was considered in review on March 19, 2010 with recommendation for non-certification. A peer discussion was realized. Per the reviewer, since the patient has been documented to have a successful diagnostic MBB and radiofequency ablation at the same level with benefit, a repeat MBB was not supported. The provider desired to modify the request to radiofrequency neurotomy which could be supported;

however, the request would need to be resubmitted. It was explained that a request for radiofrequency neurotomy would be supported, without repeating the MBB.

Request for reconsideration lumbar medial branch block at left L4-5, L5-S1 (repeat facet joint medial branch block) was considered in review on April 6, 2010 with recommendation for non-certification. A peer discussion was attempted but not realized. Per the reviewer, the patient has had rhizotomy procedures in the past and has done well. He has a history of spinal cord stimulator with a complication of infection requiring revision. He was then unable to tolerate the stimulator due to psoriasis and infection issues. He also has a history of lumbar surgery. He was authorized for a bilateral L4-5 and L5-S1 medial branch block on 10/21/08 and last had a denervation rhizotomy on the left at L4-5 and L5-S1 on 02/09/09. He has a history of good response to rhizotomy lasting up to 18 months. He has complicating factors of coronary artery disease and has been placed on Coumadin and Plavix for this issue. He has been approved to be off his cardiac meds for one week prior to performing MBB. Historically he has been a strong responder to these blocks and denervation procedures. His pain is currently rated as 8/10 and objective exam notes tenderness over the SI area. Straight leg raise is positive and sensation is intact. A call back was not received from the provider.

Request was made for an IRO.

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

Per ODG, Criteria for the use of diagnostic blocks for facet "mediated" pain: One set of diagnostic medial branch blocks is required with a response of at least 70%. The pain response should be approximately 2 hours for Lidocaine.

The patient is status post a lumbar surgery (date and procedures not reported) and has chronic pain associated with a failed back surgery. He used a spinal cord stimulator which had to be removed due infection and was later re-implanted in August 2004.

The patient underwent bilateral L4-S1 medial branch blocks in July 2007 followed by RFA. He also underwent two epidural injections that year. On October 31, 2008 the patient underwent repeat left L4, L5 and S1 medial branch blocks which identified pain symptomatology over the left lower facet region. On February 9, 2009 the patient underwent repeat left L4-S1 rhizotomy. He went off his cardiac blood thinners briefly for the procedure. On January 28, 2010 medial branch blocks at left L4, L5, S1 were again requested. This request was repeated on March 9, 2010. If the blocks are positive, he will need to go off the Coumadin and Plavix also for the rhizotomy procedure.

Per the first-line reviewer, the patient has already undergone medial branch blocks with positive response. ODG does not support repeat MBB, but does support rhizotomy with positive response to MBB. The provider desired to modify the request to radiofrequency neurotomy which could be supported; however, the request would need to be resubmitted. It was explained that a request for radiofrequency neurotomy would be supported, without repeating the MBB.

Per the second-line reviewer, the patient was authorized for a bilateral L4-5 and L5-S1 medial branch block on 10/21/08 and last had a denervation rhizotomy on the left at L4-5 and L5-S1 on 02/09/09. He has a history of good response to rhizotomy lasting up to 18 months. He has been approved to be off his cardiac meds for one week prior to performing MBB. Historically he has been a strong responder to these blocks and denervation procedures. His pain is currently rated as 8/10 and objective exam notes tenderness over the SI area. Straight leg raise is positive and sensation is intact. A call back was not received from the provider.

Per ODG one set of diagnostic medial branch blocks is required with a response of 70%. The patient has undergone medial branch blocks on multiple occasions with a positive response and has also undergone facet rhizotomy on multiple occasions with a good response. Repeated medial branch blocks would not be supported and do not appear warranted given this prior history of favorable response to facet rhizotomy. Also given the risks associated with being off anti-coagulation medications, one procedure would be preferable than two.

Therefore, my recommendation is to agree with the previous non-certification for left L4-5, L5-S1 medial branch 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

__X___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 (04-16-2010), Low Back Chapter, Facet joint diagnostic blocks (injections): 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.

Criteria for the use of diagnostic blocks for facet "mediated" pain:
1. One set of diagnostic medial branch blocks is required with a response of at least 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 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.

According to the Official Disability Guidelines: Low Back Chapter
Facet joint medial branch blocks (therapeutic injections):

Not recommended except as a diagnostic tool. Minimal evidence for treatment.

ODG TWC 04-16-2010 - Lumbar - Facet Joint radiofrequency Neurotomies:
Criteria for use of facet joint radiofrequency neurotomy:
(1) Treatment requires a diagnosis of facet joint pain using a medial branch block as described above. See Facet joint diagnostic blocks (injections).
(2) While repeat neurotomies may be required, they should not occur at an interval of less than 6 months from the first procedure. A neurotomy should not be repeated unless duration of relief from the first procedure is documented for at least 12 weeks at = 50% relief. The current literature does not support that the procedure is successful without sustained pain relief (generally of at least 6 months duration). No more than 3 procedures should be performed in a year's period.
(3) Approval of repeat neurotomies depends on variables such as evidence of adequate diagnostic blocks, documented improvement in VAS score, and documented improvement in function.
(4) No more than two joint levels are to be performed at one time.
(5) If different regions require neural blockade, these should be performed at intervals of no sooner than one week, and preferably 2 weeks for most blocks.
(6) There should be evidence of a formal plan of additional evidence-based conservative care in addition to facet joint therapy.