

Notice of Independent Review Decision

DATE OF REVIEW: OCTOBER 15, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right Medial Branch Nerve Block IV Sedation Contrast under Fluoroscopy L2-L3,
Left Medial Branch Nerve Block IV Sedation Contrast under Fluoroscopy L2-L3,
with Epidurography.

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

This physician is Board Certified by American Board of Physical Medicine and
Rehabilitation with 14 years of experience.

REVIEW OUTCOME

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

- Upheld (Agree)
 Overturned (Disagree)
 Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not
medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

On June 30, 2009, an MRI of the lumbar spine was performed. Impression: 1. Spondylosis change L3-L4 with bilateral posterolateral disc protrusions. 2. Ligamentum flavum and facet hypertrophy. 3. Mild degenerative scoliosis as interpreted by M.D.

On June 16, 2010, M.D., an anesthesiology and pain management physician evaluated the claimant. She stated she attended physical therapy for 2 weeks following the injury. She reported intermittent numbness in the bilateral feet, left greater than right. There is pain with palpation at the facet joints at L3-4. Straight leg raising is negative bilaterally, deep tendon reflexes 2+ and equal bilaterally in the lower extremities and motor strength is 5 out of 5 and equal bilaterally. Impression: L3-4 facet joint syndrome bilaterally left greater than right. 2. L3-4 spondylitic changes with bilateral posterolateral disc protrusion.

On July 19, 2010, the claimant was re-evaluated by M.D. Her pain is described as constant dull aching to sharp pain radiating down both her lower extremities left greater than right with numbness and tingling into the left foot. She is currently on Hydrocodone and Tramadol for pain management. She had a positive straight leg raise on the left at 40 degrees.

On July 29, 2010 M.D. performed the following procedures: 1. Intralaminar lumbar epidural steroid injection at the L3-4 level. 2. Fluoroscopic guidance of the needle. 3. Lumbar epidurogram and interpretation of the epidurogram. 4. IV conscious sedation. 5. Coverage and observation for 24 hours post-procedurally.

On August 5, 2010, the claimant was re-evaluated by M.D. She stated that she received about 30% pain relief from the ESI and her VAS score has dropped from a 9 to a 6. She is not complaining of numbness in her feet. Straight leg raising causes mild nerve tension pain down both lower extremities. Motor, sensory and reflex testing are within normal limits.

On August 23, 2010, M.D. a physical medicine and rehabilitation physician, performed a utilization review on the claimant. Rational for Denial: The request does not meet recommendations made with ODG Guidelines. ODG does not recommended use of sedatives during medial branch nerve block procedures as these may negate results of diagnostic testing. There is no evidence of extreme anxiety for this patient that would require IV sedation at this point in time. Therefore, it is not certified.

On September 24, 2010, M.D. an anesthesiologist, performed a utilization review on the claimant Rational for Denial: the physical examination findings did not specifically state a normal straight leg raising exam and tenderness to palpation in the requested facet locations. The submitted documents also do not include the progress therapy reports of recent evidence based rehabilitative program and

optimized pharmacological treatments showing failure. There is not note of the extreme anxiety to justify the need for IV sedation. Therefore, it is not certified.

PATIENT CLINICAL HISTORY:

On xx/xx/xx, the claimant sustained an injury to her the left hip, buttock, left ankle and low back when she was testing a fire panel and when she turned to the left to step away her left foot go stuck on an uneven surface causing her to fall on her left hip and buttock.

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

The previous decisions are upheld. ODG Guidelines Low Back Chapter recommends facet joint medial branch block as a diagnostic tool with suggested indicators of pain related to facet joint pathology as tenderness to palpation over facet region, normal sensory exam, absence of radicular pain and normal SLR. Medial Branch Block are limited to claimants with low back pain that is non-radicular, performed no more than 2 levels, documented failure of conservative care more than 4-6 weeks, and use of IV sedation may negate results and only given in extreme anxiety.

In this case there is radicular pain with positive SLR, there is no documentation of facet tenderness, there is no documented failure of conservative care and no documentation of extreme anxiety.

Facet joint medial branch blocks (therapeutic injections)

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

Pain Physician 2005: In 2005 Pain Physician published an article that stated that there was moderate evidence for the use of lumbar medial branch blocks for the treatment of chronic lumbar spinal pain. (Boswell, 2005) This was supported by one study. (Manchikanti, 2001) Patients either received a local anesthetic or a local anesthetic with methyl prednisolone. All blocks included Sarapin. Sixty percent of the patients overall underwent seven or more procedures over the 2½ year study period (8.4 ± 0.31 over 13 to 32 months). There were more procedures recorded for the group that received corticosteroids that those that did not (301 vs. 210, respectively). ["Moderate evidence" is a definition of the quality of evidence to support a treatment outcome according to Pain Physician.] The average relief per procedure was 11.9 ± 3.7 weeks.

Pain Physician 2007: This review included an additional randomized controlled trial. (Manchikanti², 2007) Controlled blocks with local anesthetic were used for the diagnosis (80% reduction of pain required). Four study groups were assigned with 15 patients in each group: (1) bupivacaine only; (2) bupivacaine plus Sarapin; (3) bupivacaine plus steroid; and (4) bupivacaine, steroid and Sarapin. There was no placebo group. Doses of 1-2ml were utilized. The average number of treatments was 3.7 and there was no significant difference in number of procedures noted between the steroid and non-steroid group. Long-term improvement was only thought to be possible with repeat interventions. All groups were significantly improved from baseline (a final Numeric Rating Scale score in a range from 3.5 to 3.9 for each group). Significant improvement occurred in the Oswestry score from baseline in all groups, but there was also no significant difference between the groups. There was no significant difference in opioid intake or employment status. There was no explanation posited of why there was no difference in results between the steroid and non-steroid groups. This study was considered positive for both short- and long-term relief, although, as noted, repeated injections were required for a long-term effect. Based on the inclusion of this study the overall conclusion was changed to suggest that the evidence for therapeutic medial branch blocks was moderate for both short- and long-term pain relief. (Boswell², 2007) Psychiatric comorbidity is associated with substantially diminished pain relief after a medial branch block injection performed with steroid at one-month follow-up. These findings illustrate the importance of assessing comorbid psychopathology as part of a spine care evaluation. (Wasan, 2009) 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).

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 FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)