

# P&S Network, Inc.

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## Notice of Independent Review Decision

### MEDICAL RECORD REVIEW:

**DATE OF REVIEW:** 09/13/2010

**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**

Outpatient lumbar medial branch blocks

### **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 10-10-01 Operative report - lumbar fusion - from Dr.
- o 10-10-01 Lumbar radiographic report read by Dr.
- o 04-22-02 Follow-up report from Dr., DC
- o 04-29-02 Impairment Rating MMI report from Dr.
- o 07-18-02 MMI report from Dr., DC
- o 04-30-03 Operative report ESI from Dr.
- o 05-19-03 Lumbar MRI read by Dr.
- o 05-23-03 IME report from Dr.
- o 03-17-10 Initial evaluation report from Dr., DC with DWC-73
- o 05-07-10 Chiropractic office visit report from Dr. with DWC-73
- o 05-07-10 Pain Management - Initial Office Visit report from Dr.
- o 05-19-10 Lumbar MRI read by Dr.
- o 05-25-10 Pain Management follow-up visit report from Dr. and
- o 05-25-10 Encounter Summary from Dr.
- o 06-11-10 Fax Preauthorization Request from Dr.
- o 06-11-10 Request for Records from Dr., DC
- o 06-21-10 Chiropractic visit report from Dr., DC
- o 06-21-10 DWC-73 from Dr., DC
- o 06-23-10 Med-Legal Report from Dr.
- o 06-24-10 Notice of UR findings from
- o 06-24-10 Letter to Claimant from
- o 07-02-10 Pain Management - Letter of Medical Necessity from Dr.
- o 07-06-10 Fax Preauthorization Request from Dr.
- o 07-13-10 Notice of UR review findings from

- o 07-13-10 Letter to Claimant from
- o 08-18-10 Request for IRO from the Claimant
- o 08-24-10 Notice to P&S of Case Assignment from TDI
- o 08-27-10 Confirmation of Receipt of Request for IRO from TDI

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

According to the medical records, the patient is a female employee who sustained an industrial injury to the low back on xx/xx/xx when lifting a box of soda.

Operative report of October 10, 2001 describes lumbar surgery with discectomy and laminectomy L5-S1 bilaterally with posterior lumbar interbody fusion L5-S1 for a patient with herniated disc and left leg pain unresponsive to conservative treatments.

Medical report of April 22, 2010 indicates the patient is being followed for recurrent low back pain. She has had a CT myelogram and has been determined to be not surgical. She has been getting epidural injections.

According to an IME report of April 29, 2002 the patient's chiropractic provider diagnosed a herniation at L5-S1. She failed conservative treatment and underwent surgery on October 2001 with a fusion at L5-S1. In January 2002 her surgeon felt she has a solid fusion with no hardware failure. She has been in rehab and a work conditioning program which she stopped due persisting or increasing pain. She says her left lower extremity has improved but her lower back pain continues. She should lay off the work conditioning and focus on her HEP. She will likely reach statutory MMI in October 2002.

The patient reached MMI in July 2002 per her treating chiropractor and was assigned impairment (percent unknown due date stamp obliterating the amount). She was recommended to participate in a chronic behavioral pain management program.

The patient was provided a left S1 transforaminal selective ESI on April 30, 2003. She is not working.

Open lumbar MRI of May 19, 2003 was given impression: 1. Disc desiccation at T12-L1 with small broad-based midline disc protrusion. 2. Early disc desiccation at L1-2 and L2-3 with mild/minimal posterior annular bulging. 3. Disc desiccation at L3-4 with mild posterior bulging of the disc. 4. Mild disc desiccation at L4-5 with mild bulging of the disc. Mild degenerative facet disease is present and all of these changes mildly narrows the central spinal canal. Postoperative changes at L5-S1."

The patient underwent an IME on May 28, 2003. She is using a cane and a brace. She says she may need surgery again. They plan a hardware injection. Nerve studies show an acute L5-S1 radiculopathy, which was not present prior to the surgery. She also has diabetes. She is 5' 5" and about 208 pounds. Previously she was about 220 pounds. The only surgery that should be considered is hardware removal.

The patient was lost to treatment for several years. She was reevaluated by her chiropractic provider on March 17, 2010. She continues to complain of low back and leg pain. She does get some right leg numbness and occasionally drags the right leg. Sensation and reflexes are abnormal on the right lower extremity. Right EHL strength is 4/5. A pain management evaluation and updated MRI are recommended.

At reevaluation on May 7, 2010 the patient reported a pain level of 10/10. She reports low back pain and pain into the left lower extremity.

Updated lumbar MRI performed May 20, 2010 was given impression: 1. At L4-5 there are prominent bilateral degenerative facet changes. There is a mild broad based disc bulge. Combined changes result in moderate to severe central canal stenosis and mild to moderate right neural foraminal stenosis. 2. At T12-L1 a posterior central disc bulge indents the central thecal sac resulting in minimal central canal narrowing in the midline. 3. Milder degenerative changes at other levels as discussed above. 4. Postoperative changes at L5-S1 without significant central canal stenosis or neural foraminal narrowing at this level.

On May 25, 2010 the patient was prescribed Flector patches and Vicodin and recommended to undergo lumbosacral medial branch blocks for a diagnosis of thoracic or lumbosacral neuritis or radiculitis.

The patient was reevaluated on June 21, 2010. An MRI was done and shows a disc herniation. She has about 40 degrees of lumbar flexion and extension is not really past neutral. Lumbar rotary extension procedures are rather painful bilaterally. She has spasm that is moderate to moderately severe in the lumbar paraspinal muscles. She was given a lumbar brace. Hopefully she will get the injections that have been recommended.

The patient was provided a pain management consultation on May 7, 2010. She has had a fusion at L5-S1 and a subsequent surgery to remove the hardware. She has pain with flexion and extension. She is complaining of posterior leg pain on the left and anterior leg pain on the right. Right EHL strength is weak. Straight leg raise is positive left and right. Diagnosis is post laminectomy syndrome, lumbar radiculopathy and low back pain. Recommendation is for an updated MRI and hydrocodone.

The patient returned to pain management on May 25, 2010. Hydrocodone makes her drowsy. The MRI shows prominent bilateral facet changes at L4-5 with a disc bulge resulting in severe central canal stenosis and moderate right neural foraminal stenosis. She will continue hydrocodone at a lesser dosage and Lyrica and will try Flector patches. She will be scheduled for lumbar medial

branch blocks as soon as approved.

Medical records were reviewed and med-legal opinions provided on June 23, 2010. She attended a chronic pain management program in 2005. Her symptoms are related to the original on the job injury. The treatment has been compliant with the ODG. However, in regard to medial branch blocks, the presence of both spinal stenosis and previous fusion precludes performing such a procedure at this point. The findings on the MRI of May 13, 2010 are not directly contributory to the original injury but are compatible with the normal aging process.

Request for outpatient lumbar medial branch blocks was considered in review on June 24, 2010 with recommendation for non-certification. Per the reviewer the patient reported a pain level of 10/10 on May 7, 2010. The current report dated May 25, 2010 notes low back pain that travels to the right leg to the knee. There was also decreased dorsiflexion strength on the right and a positive straight leg raise on the right. The criteria for medial branch blocks includes low back pain that is non-radicular and at no more than two levels bilaterally. As ODG does not recommend medial branch blocks when radicular pain is present, there is not sufficient documentation or rationale for lumbar medial branch blocks, thus the request is not medically reasonable or necessary.

Per letter of July 2, 2010 the provider states the patient has in the past had some episodes of right-sided leg pain. She has had a lumbar fusion at L5-S1 in the past. An updated MRI reveals there have been no changes in the disc areas of her spine. The MRI is significant for bilateral degenerative facet changes at L4-5 and post-operative changes at L5-S1. In lieu of the fact that she is mostly complaining of low back pain and not so much radicular pain, we were hoping to try to give her some relief with lumbar medial branch blocks. We are actually requesting to do both sides from L3 to L5 to hopefully give her some relief and get her back to her daily activities with a minimum amount of back pain.

Request for reconsideration outpatient lumbar medial branch blocks was considered in review on July 13, 2010 with recommendation for non-certification. Rationale for denial states the claimant has reportedly undergone a fusion at L5-S1. Utilizing medial branch blocks at the level of a fusion is not supported by the ODG. It is also noted that the claimant has leg pain as well that could be radicular in nature. Therefore, this request does not meet the ODG 15th edition.

Request was made for an IRO.

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

ODG does not recommend medial branch blocks when radicular pain is present. Additionally, ODG does not recommend diagnostic facet blocks be performed in patients who have had a previous fusion procedure at the planned injection level.

According to the IME of May 23, 2003 nerve studies show an acute L5-S1 radiculopathy, which was not present prior to the surgery. The evaluation of March 17, 2010 noted she does get some right leg numbness and occasionally drags the right leg. Sensation and reflexes are abnormal on the right lower extremity. Right EHL strength is 4/5. Med-legal opinions of June 23, 2010 state, the presence of both spinal stenosis and previous fusion precludes performing medial branch blocks at this point. First line review denial rationale notes, the criteria for medial branch blocks includes low back pain that is non-radicular and at no more than two levels bilaterally. As ODG does not recommend medial branch blocks when radicular pain is present, there is not sufficient documentation or rationale for lumbar medial branch blocks, thus the request is not medically reasonable or necessary. Second line review rationale for denial notes, utilizing medial branch blocks at the level of a fusion is not supported by the ODG.

It is also noted that the claimant has leg pain, numbness, weakness in the right lower extremity, as well as underlying spinal stenosis and a previously abnormal EMG study. Initially the provider desired medial branch blocks at L4-5 but most recently reported, we are actually requesting to do both sides from L3 to L5. Given the multiple references to the presence of radiculopathy and prior fusion at L5-S1, the requested procedures are not supported by the ODG.

Therefore, my recommendation is to agree with the previous non-certification for outpatient lumbar 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
- 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 08-30-2010 Lumbar Chapter - Facet joint diagnostic blocks (injections):

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. [Exclusion Criteria that would require UR physician review: Previous fusion at the targeted level. (Franklin, 2008)]