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**Notice of Independent Review Decision**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

The item in dispute is the prospective medical necessity of bilateral facet nerve block L1/2/3 (64493, 64494, 77003, 99144).

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

The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation. The reviewer has been practicing for greater than 10 years.

**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)

The reviewer disagrees with the previous adverse determination regarding the prospective medical necessity of bilateral facet nerve block L1/2/3 (64493, 64494, 77003, 99144).

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The injured worker sustained injuries to the back and left lower extremity XX/XX/XXXX when a heavy piece of equipment fell on top of him. He sustained a compression fracture of the L1 vertebra and a fracture of the left foot.

He was seen by Dr. on XX/XX/XXXX for evaluation and treatment. Dr. reviewed x-rays and a CT scan of the left foot which were reported to show nondisplaced fractures of the left cuboid and of the left calcaneus, extending into the talocalcaneal joint. Recommended treatment included placement in a cast and strict non-weight bearing for 2-3 months.

On June 16, 2010 Dr. performed percutaneous vertebroplasty with methyl methacrylate injection bilaterally, after using expansion balloons to reduce the L1 vertebral compression fracture. Dr. saw the patient September 28, 2010. The injured worker reported no improvement after the vertebroplasty, stating that he continues to have very severe lower back pain and leg paresthesia. Dr. referred the injured worker to Dr. for pain management. Medications were adjusted.

On October 14, 2010, Dr. found him not to be at MMI. The foot pain had resolved but back pain persisted. On November 4, 2010 the injured worker was evaluated by Dr., who felt that the patient had developed a chronic pain type syndrome not responsive to the typical treatment modalities.

On December 7, 2010 Dr. saw the injured worker for neurological surgery consultation. He documented that the patient had seen multiple other doctors. He had MRIs of his lumbar spine but never had a CT scan or EMG/nerve conduction velocity studies of bilateral lower extremities. He had undergone physical therapy before surgery and after surgery. On examination the injured worker walked with a cane in the right hand.

Musculoskeletal examination revealed no muscle wasting or fasciculations and no weakness demonstrable in the upper or lower extremities, "except for pain limited". Deep tendon reflexes were 2+ and symmetric except for 3+ biceps, patellar and Achilles reflexes. Dr. reviewed x-rays, reporting them to show evidence of cement in the L1 vertebra and also in the T12-L1 disk space, with no gross movement on flexion and extension views. On the AP view of the lumbar spine there was question of a right pars defect at L4. Dr. reviewed the MRI of the lumbar spine from August 20, 2010, noting that it showed L1 post kyphoplasty without any retropulsion or central or neural foraminal stenosis. He noted that there was evidence of a "slight hyperintensity in the superior part of the vertebra

of L5 on the T1 but it is hypointense on STIR sequence". Dr. diagnosed the following:

- Low back pain, at the thoracolumbar junction and lumbosacral junction.
- L1 fracture status post kyphoplasty in June.
- Lumbar spondylolysis, pars defect, questionable on the right on x-ray.
- Scoliosis, mild convex left of the lumbar spine.
- Dorsal thoracic pain.
- Neck pain.
- Hyperreflexia at biceps bilaterally and bilateral lower extremities.
- Paresthesias in upper extremities and lower extremities bilaterally.

Dr. recommended CT of the lumbar spine to evaluate the right L5 pars region along with EMG/nerve conduction velocity studies of bilateral lower extremities and bilateral upper extremities, given the paresthesias. He recommended a MRI of the cervical and thoracic spine without contrast given the hyperreflexia on the physical examination.

On the follow-up visit December 30, 2010 Dr. reviewed CT of the lumbar spine performed December 28, 2010, which showed the L1 old compression fracture treated with kyphoplasty. At L5-S1 there were mild degenerative arthritic changes of the right facet joint with mild diffuse bulging of the annulus. There was cement in the T 12-L1 disk space. He noted that the EMG/nerve conduction studies performed by Dr. December 15, 2010 showed no sign of denervation potentials, brachial plexopathy, and/or myopathic changes. The nerve conduction studies showed peroneal motor and sensory demyelinating axonal neuropathy along with bilateral sural neuropathy. Dr. stated that the patient does not have a surgical lesion to explain his pain. "Therefore, he will likely have to continue with pain management but options such as injections, either epidural steroid injections or facet, and/or spinal cord stimulator trial was discussed with him".

On February 22, 2011 Dr. stated in a letter that the injured worker needed to be considered for a spinal cord stimulator followed by some rehab, but that he had been "shut off all of his medical including his medications. He had to be put on narcotic medication due to the severity of his pain and when this was suddenly stopped he has gone through severe withdrawal". Included with the letter was a copy of part of the printout from the EMG and nerve conduction studies performed by Dr.

On February 18, 2011 the injured workers attorney submitted a request for review, appealing the non-authorization for bilateral facet nerve blocks that had been requested by M.D. On reconsideration, the adverse determination was upheld by the reviewer. On March 10, 2011 the injured worker submitted a request for review by an IRO.

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

The injured worker meets the ODG criteria for the proposed diagnostic blocks.

According to the ODG Integrated Treatment/Disability Duration Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic) (updated 03/14/11), pertaining to 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  $\geq 70\%$ . The pain response should last at least 2 hours for Lidocaine.
2. Limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally. The pain is non-radicular. No evidence of radiculopathy was seen on imaging studies or electrodiagnostic studies. The proposed blocks are limited to two levels (L1-L2 and L2-L3).
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. Treatment included therapy before and after the surgical procedure, as documented by Dr. in the December 7, 2010 evaluation. Treatment included medications prescribed by a pain management specialist.
4. No more than 2 facet joint levels are injected in one session (see above for medial branch block levels). The proposed blocks are limited to two 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. On the follow-up visit December 30, 2010 Dr. advised the injured worker that he does not have a surgical lesion to explain his pain. Treatment options, including injections, were discussed.
11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level.

The patient meets the above mentioned criteria. Therefore, the procedure is medically necessary at this time.

**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)