

SENT VIA EMAIL OR FAX ON
Jun/16/2011

Pure Resolutions Inc.

An Independent Review Organization
990 Hwy 287 N., Ste. 106 PMB 133
Mansfield, TX 76063
Phone: (817) 405-0870
Fax: (512) 597-0650
Email: manager@pureresolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jun/16/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Bilateral L4/5 and L5/S1 Medial Branch Block Injection Diagnostic no Steroid with Sedation

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

Texas licensed MD board certified in anesthesiology and pain management

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY SUMMARY

The injured employee is a male who is reported to have sustained work related injuries on xx/xx/xx. It's reported that on the date of injury he started to feel pain in the groin area on both sides. The pain is especially worse when he bends down and tries to pick something up. On 02/01/11 he was initially evaluated at medical center by Dr. who notes the history above. He reports he has no urinary incontinence, no pain down the legs. He's noted to have a history of neck and low back problems. He's reported to have a history of back and neck surgery. He had a knee injury and a left total knee replacement approximately 15 years ago. On physical examination he was in no apparent distress. His gait is normal without evidence of a limp. Lumbar range of motion is decreased in flexion with pain in extension at 5 degrees. Sensation is intact. Palpation is negative for pain. Reflexes are normal and symmetric. Straight leg raise is negative bilaterally. He has normal strength in the lower extremities. He was diagnosed with trunk strain inguinal and a lumbar strain. Radiographs of the lumbar spine showed diffuse osteophytes from L3 through L5. There is a metal plate fusing the L3-4 vertebra. He was subsequently referred for physical therapy and treated with oral medications. On 03/02/11 the injured employee was seen by Dr.. The injured employee is reported to have been injured on xx/xx/xx while doing some activities that he typically does not do. He then started feeling pain in the low back and into the groin which continued to worsen over the next several days. He had x-rays over the lumbar spine which showed diffuse osteophytes at L3 through L5 with a metal plate from his fusion at L3-4. He's been treated with medications and been placed on modified duty and he was referred for physical therapy. He's reported to have a history of back surgery two years ago but states he was doing well after that and he had neck surgery three years ago. Both of these surgeries were non-work related. He's reported to have pain across the low back which is a burning like pain radiating into the groin just under the testicles especially with lifting and moving around. He has no further radiation down the extremities. He has no sensory deficits or paresthesias. He's taking ibuprofen once a day and Vicodin at night. On physical examination he's 5'8½" tall. He weighs 295 pounds. He's normotensive, tender in the paraspinals left more than right, has no

muscle spasms or trigger points. Forward flexion is to 45 degrees, extension is to 10. He has some mild discomfort noted with Faber's test on the right negative on the left. Motor exam is graded as 5/5. Sensation is subjectively intact throughout. Reflexes are absent at the patella and Achilles bilaterally. His gait is essentially normal. He's able to do toe raises. He has a negative straight leg raise in the sitting and supine positions. Dr. opines that the injured employee will improve with conservative treatment. The injured employee's injuries appear to be myofascial. He is provided instructions and his medications were modified.

On 03/16/11 the injured employee was seen in follow up by Dr. He reports his pain level to be an 8. He still has some pain the low back that goes into the groin and testicular area. He has completed all his therapy sessions but has not seen any additional benefits. His medications do provide some benefit. He subsequently requests to see a pain management spine specialist. There is a discussion regarding CT myelogram. Physical examination was reported to be unchanged. He was to continue on a home exercise program.

On 04/12/11 the injured employee was seen by Dr. The injured employee is reported to have low back pain and pain in the bilateral lower extremities and bilateral groin pain since the date of injury. Dr. notes the history above. The injured employee reports that his pain level has gone up to about an 8/10. He reports he's unable to walk even a block without suffering from this pain. He feels better lying down, worse if he's standing, walking or getting out of a chair. He's had physical therapy and injections without relief. He reports the injection was just an in office intramuscular type. He reports his pain is predominately more on the left than the right that does not radiate. On physical examination he's 5'10" and 290 pounds. He has good range of motion with lumbar flexion without reproduction of pain with extension he has mild pain in the lumbar spine. Facet loading on the left induces significant pain on the left and minimal pain as noted on the right. Dural tension sign is mildly positive on the left and negative on the right. Range of motion is full. Lower extremity sensation is grossly intact. He has a half grade weakness in the left ankle dorsiflexor and evertor when compared to the right. There's minimal pain edema in both extremities. He is opined to have a left greater than right low back pain and left lower extremity sciatic pain with weakness in the left distal lower extremity in the L5 myotome. He subsequently is recommended to undergo MRI. If this is unremarkable he recommends bilateral lumbar facet branch blocks in the lower lumbar spine below his fusion. The records include a radiology report which indicates that the injured employee has a 360 degree pedicle hardware fusion at L3-4 with disc space narrowing at L4-5 and L5-S1. There is significant osteophyte formation and disc space narrowing from T12-L1 down to L2-3. The sacroiliac joints are open. The hip joints are unremarkable. There's a lateral projecting osteophyte at the L1-2 vertebral space. Facet hypertrophy is noted in the lower lumbar spine.

On 04/21/11 MRI of the lumbar spine was performed. This study notes a posterior disc protrusion centrally with combination of disc and spur noted to the right of midline at T12-L1 measuring 5mm. There's a deformity of the anterior aspect of the thecal sac without definite deformity of the adjacent conus. The central canal is approximately 9mm. The neural foramina are normal in calibre. There are prominent anterior osteophytes visualized at this level specifically at L1-2 anterior osteophytes are visualized with broad based ventral defect measuring 4mm most compatible with posterior disc protrusion. Degenerative facet joint changes are identified. The AP diameter of the spinal canal is 8mm. At L2-3 there are small anterior osteophytes. There is a disc which slightly exceeds bony spurs on the left of midline measuring 6mm. A right paracentral disc protrusion is identified measuring approximately 7mm. There is deformity of the anterior thecal sac. There are degenerative facet joint changes and ligamentum flavum hypertrophy. There's a subtle grade 1 spondylolisthesis. A subtle grade 1 spondylolisthesis cannot be excluded. The AP diameter of the canal is 7mm. At L3-4 there are pedicle screws, an interbody fusion graft visualized at this level, abnormal soft tissue intensity noted within the right neural foramen most likely related to post-operative changes. At the L4-5 level there's a broad based posterior disc protrusion slightly exceeding the posterior osteophytic spurs with impression on the anterolateral thecal sac. There are degenerative facet joint changes identified. The AP diameter of the canal is approximately 10mm. There's mild bilateral neural foraminal narrowing. There are findings suspicious for a small synovial cyst projecting from the anterior medial aspect of the right face joint. At L5-S1 there's a degenerative grade 1 spondylolisthesis, a 4mm broad based posterior disc bulge, no deformity of the thecal sac or the S1 nerve root sleeves, and bilateral neural foraminal narrowing demonstrated. The injured employee was seen in follow up by Dr. on 04/26/11. Dr.

subsequently recommends that the injured employee undergo diagnostic facet injections at L4-5 and L5-S1.

On 05/09/11 the request was reviewed by Dr. Dr. notes that the injured employee has a fusion at L3-4, degenerative listhesis at L5-S1. He reports there's no compelling medical reason to suspect that the facet joints are pain generators in the injured employee given his history the clinical and radiographic findings. A subsequent appeal request was submitted on 05/20/11 and reviewed by Dr. Dr. subsequently reports that there must be no fusion present in order to justify medial branch blocks. By the presence of the pedicle screws it is evident that the injured employee has fusion. He recommends non-certification.

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

The request for bilateral L4-5 and L5-S1 medial branch block diagnostic injections with sedation are medically necessary and the previous determinations are overturned. The submitted clinical records indicate that the injured employee sustained an injury to his low back as a result of increased lifting activities on the date of injury. Records indicate that the injured employee has a past history of an L3-4 fusion secondary to degenerative spinal disease. It is reported that the injured employee had returned to work with no restrictions and no subjective complaints prior to his injury. Records indicate that the injured employee has been treated conservatively with oral medications and physical therapy. Plain radiographs show evidence of effusion at the L3-4 level with multilevel degenerative changes with apparent abnormalities in the posterior elements. The injured employee's physical examination is noted to be positive for facet loading pain on extension and pain with rotation and loading of the facets. MRI of the lumbar spine dated 04/21/11 clearly indicates multilevel facet pathology both above and below the level of the previous fusion. The injured employee's physical examination is clearly consistent with facet mediated pain giving the correlative data provided by MRI and plain radiographs the injured employee in all probability has symptomatic facet disease at the lower lumbar levels. As such diagnostic facet injections at L4-5 and L5-S1 would be clinically indicated and supported under the Official Disability Guidelines.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES