

MATUTECH, INC.

PO BOX 310069
NEW BRAUNFELS, TX 78131
PHONE: 800-929-9078
FAX: 800-570-9544

Notice of Independent Review Decision

DATE OF REVIEW: November 10, 2011.

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medial branch block bilateral L3-S1.

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

The physician reviewer is duly licensed to practice medicine in the state of Texas. The reviewer is fellowship trained in pain management and board certified in anesthesiology with certificate of and qualifications in pain medicine. The reviewer has over 23 years of active and current practice in pain management.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse should be upheld.

Upheld (Agree)

Medical documentation does not support the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI

- Utilization reviews (10/4/11, 10/13/11, 10/17/11)

Liberty Mutual Group

- Diagnostics (08/11/04 – 01/08/09)
- Office visits (03/18/09 – 07/20/11)
- Utilization reviews (12/21/09 – 10/17/11)

[ODG has been utilized for the denials.](#)

PATIENT CLINICAL HISTORY [SUMMARY]:

This claimant was allegedly injured on xx/xx/xx, when she fell on her buttocks at work. Lumbar MRI on August 11, 2004, demonstrated nothing more than L1-L2, L3-L4 and L4-L5 disc dehydration and diffuse L3-L4 through L5-S1 disc bulging. No disc herniation, spinal stenosis or neural compromise was noted at any level. The radiologist interpreted the MRI as demonstrating “no significant abnormality”.

A lumbar CT scan was then performed at the request of chiropractor on January 13, 2005, demonstrating suggestive evidence of partial L4-L5 radial tear and left L5-S1 radial tear not extending beyond the annulus.

Yet another MRI was performed four years later on January 8, 2009, demonstrating nothing more than mild L3-L4 disc bulge with no spinal or foraminal stenosis and no nerve root compression. The study was again termed “unremarkable”.

On March 18, 2009, the claimant was evaluated by Dr. who has continued treating her through the present. He noted the claimant had undergone epidural steroid injections with no more than one or two weeks of relief and then IDET procedure similarly without benefit. The claimant's pain level was said to be 10/10. Physical exam documented normal strength and reflexes. A straight leg raising test was positive at 45 degrees bilaterally but a negative Patrick's test. Dr. recommended lumbar discography as a prelude and preoperative workup, but the claimant expressed no interest in surgery.

Dr. followed up with the claimant on April 1, 2009, documenting her continued lumbar pain which “gradually worsening” lumbar radiculopathy into both lower extremities. Physical exam documented nothing more than nonspecific facet tenderness and nonspecific decreased range of motion.

On May 18, 2009, Dr. again followed up with the claimant stating that she had “low back pain and lumbosacral radiculitis secondary to herniated nucleus pulposus” when, in fact, no lumbar MRI or CT scan ever demonstrated such a finding. Physical exam was unchanged, and the claimant was sent for psychological evaluation for spinal cord stimulator trial. The psychologist stated the claimant needed psychotherapy prior to consideration of a spinal cord stimulator trial.

On July 15, 2009, Dr. followed up with the claimant documenting exactly the same non specific physical exam findings and continued refilling of Soma b.i.d., Lidoderm patch, Ambien and hydrocodone 10 mg q.i.d. On August 11, 2009, Dr. again followed up with the claimant, documenting the same nonspecific exam findings as well now as bilateral L5 distribution paresthesia.

On November 23, 2009, Dr. again followed up with the claimant documenting facet tenderness in the L3 to L5 and nonspecific flexion and extension deficits with the same paresthesia now in the L4 and L5 dermatomes bilaterally. The claimant was subsequently cleared by Dr. a psychologist, for a spinal cord stimulator trial on December 14, 2009, after she noted that the claimant's MMPI-II testing had improved by following 14 sessions of psychotherapy.

On January 11, 2010, Dr. performed a dual-lead spinal cord stimulator trial. The claimant returned for follow up on January 18, 2010, reporting absolutely no pain relief from the spinal cord stimulator trial and “immense” pain at the lead insertion side. Dr. termed this a “failed trial”.

On September 2, 2010, Dr. followed up with a claimant again documenting nonspecific facet tenderness and range of motion deficits with a positive straight leg raising at 50 degrees bilaterally.

On October 6, 2010, Dr. again followed up with the claimant noting her unchanged pain level of 9/10 despite having changed opiates to a long-acting Opana ER. Physical exam was exactly the same and Dr. switched Opana ER to fentanyl patch. The claimant subsequently continued to use ever increasing doses of opiates with no significant improvement in pain and no change in non specific exam findings. The claimant also developed side effects from the opiates.

On April 1, 2011, the claimant returned to Dr. with the same complaints of lower back pain, radiculitis and "herniated nucleus pulposus". Physical exam documented nonspecific facet tenderness and decrease range of motion as well as L4 and L5 dermatomal paresthesia with positive straight leg raising bilaterally at 50 degrees. Dr. requested bilateral L3 through S1 medial branch block.

On April 27, 2011, the claimant returned to Dr. who noted that the request for medial branch blocks had been denied. Physical examination demonstrated the same findings, the pain level was the same and medications were continued. Dr. a spine surgeon, evaluated the claimant on May 4, 2011, for her continued "discomfort radiating into her buttock and leg". The claimant complained of pain and numbness in the low back and both legs as well as weakness. Dr. however, documented no musculoskeletal or neurologic exam. In fact, all he documented was heart rate, blood pressure, temperature and vital signs. He reviewed the claimant's MRI which she noted showed "mild L3-L4, L4-L5, L5-S1 degenerative disc disease with no significant compression". Despite that interpretation he diagnosed the claimant with lumbar disc herniation, which, clearly, is incorrect.

On May 25, 2011, Dr. followed up with the claimant noting that despite ever increasing doses of the fentanyl patch she was not obtaining relief. Physical exam documented the same nonspecific findings. Dr. discontinued the fentanyl patch and started methadone.

On June 9, 2011, a physician advisor reviewed the request for bilateral medial branch blocks, finding them not medically reasonable or necessary according to ODG treatment guidelines.

On June 20, 2011, Dr. followed up with the claimant noting her continued "lower back pain, lumbosacral radiculitis and exquisite facet pain". Pain level remained unchanged despite addition of methadone and continued use of muscle relaxants and hydrocodone.

A second preauthorization review was performed by a different physician on July 18, 2011, who also found the request to not be medically reasonable or necessary according to ODG treatment guidelines.

On July 20, 2011, Dr. followed up with the claimant, documenting the same "lower back pain and lumbosacral radiculitis" with the same pain level of 8/10 and the same physical exam findings of L3 through S1 facet tenderness worse left and L3, L4 and L5

dermatomal paresthesia bilaterally. He refilled methadone, Nuvigil, Norco, Parafon forte, Lidoderm and Zofran.

A peer review was then performed on October 3, 2011, by an anesthesiology pain management specialist. In that review, the reviewer cited ODG treatment guidelines as proof of the claimant not meeting criteria for requested bilateral L3 through S1 medial branch blocks. A second peer review by a different anesthesia pain management specialist concurred with the recommendation for non authorization of the requested procedure, also citing ODG treatment guidelines.

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

According to the ODG treatment guidelines, diagnostic medial branch blocks are “limited to patients with low back pain that is non radicular” and are limited to “no more than two levels bilaterally”. Therefore, this claimant does not meet ODG criteria for bilateral L3 through S1 medial branch blocks. The claimant has had continuous complaints of radicular pain for at least the last six years, as well as physical examination evidence of positive bilateral straight leg raising test. The presence of radicular pain is a contraindication to performing medial branch block, making this request medically unreasonable and unnecessary. Additionally, the request is for four levels bilaterally, which exceeds ODG treatment guidelines. Even if the request was only for a two level block, the claimant would not meet ODG criteria based upon the continuous complaint of radicular pain and examination evidence of positive bilateral straight leg raising test. Therefore, the previous physician advisor and peer review recommendations for non authorization of the requested procedure, medial branch block bilateral L3-S1, are upheld. The requested procedure is not medically reasonable or necessary, nor is it supported by ODG treatment guidelines.

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

odg- official disability guidelines & treatment guidelines