CASEREVIEW

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Notice of Independent Review Decision

DATE OF REVIEW: February 16, 2012, Amended February 16, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Bilat L4-5-S1 medial branch block facet #1 64493 x 2/ 64494 x 2/ 64495 x2 77003-99144 to complete by 12-24-12

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
This physician is Board Certified Physical Medicine and Rehabilitation with over 15 years of experience.

REVIEW OUTCOME:

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

☒ Upheld (Agree)

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:
01/31/11: CT Chest, Abdomen, and Pelvis with IV Contrast interpreted by MD
05/17/11: New Patient Office Visit at Pain Associates by MD
07/20/11: Lumbar Myelogram with CT Myelography of the Lumbar Spine interpreted by MD
08/23/11: Established Patient Office Visit at Pain Associates by MD

10/03/11: Established Patient Office Visit at Pain Associates by MD
11/01/11: Established Patient Office Visit at Pain Associates by MD
11/09/11: Pre-Authorization Request from Pain Associates
11/14/11: UR performed by MD
12/05/11: Appeals Letter by MD
12/12/11: Pre-Authorization Request from Pain Associates
12/15/11: UR performed by MD
12/28/11: Medication Management Office Visit at Pain Associates by PA-C
01/17/12: Established Patient Office Visit at Pain Associates by MD

PATIENT CLINICAL HISTORY [SUMMARY]:
This claimant was injured in xx/xx/xx when he sustained a fall while at work. He fell sideways landing on his right side over an open drawer on his desk. He sustained a right T10, T11, and T12 rib fracture and a right L1 transverse process fracture. It should be noted he is status post an L2-L5 lumbar decompression and fusion performed in January of 2010.

On xx/xx/xx, a CT Chest, Abdomen, and Pelvis with IV Contrast was performed. Impression: 1. Right T10, T11, and T12 rib fractures. 2. Right L1 transverse process fracture. 3. Prior cervical fusion. 4. Prior coronary artery bypass graft. 5. Prior lumbar spine fusion.

On May 17, 2011, the claimant was evaluated by MD for localized low back pain with radiation of symptoms into the posterior aspects of bilateral thighs with intermittent cramping sensation in bilateral calves, right greater than left. The claimant was diagnosed with a lumbar back strain. Dr. recommended a trial for both diagnostic and therapeutic purposes bilateral L5-S1 intraarticular facet joint injection using local anesthetic and steroid. He was also prescribed Tramadol.

On July 20, 2011, a Lumbar Myelogram with CT Myelography of the Lumbar Spine was performed. Impression: Suspected interval increase in size or recurrence of a right lateral disc protrusion at L4-5 substantially encroaching on the thecal sac and probably impinging upon the intradural portion of the distal right L5 root as well is disc protrusion extending into the right intervertebral neural foramen and probably encroaching upon the right L4 root.

On August 23, 2011, the claimant was re-evaluated by MD who found on physical examination very localized lumbosacral paraspinal muscle tenderness to palpation, right greater than left. There was also mild facet joint tenderness to palpation at approximately L4-5 and L5-S1 levels. No Si joint or gluteal muscle tenderness to palpation bilaterally. There was very limited forward flexion, as well as spinal extension secondary to mechanical limitations, as well as provocation of localized right low back pain with forward flexion and extension. Sensation was mildly decreased to light touch along lateral aspect of right thigh and right lower leg, as well as posterior aspect of the right thigh in comparison to the left. DTRs were trace in patellae and Achilles

bilaterally. Dr. assessment was persistent low back pain, now with symptoms of possible lumbar radiculopathy in an L5, S1 distribution with known right lateral disc protrusion at L4-5 with possible impingement of right L5 and right L4 distal nerve root on recent lumbar myelogram. Dr. recommended a right L5 transforaminal epidural steroid injection.

On October 3, 2011, the claimant was re-evaluated by MD who reported the claimant had completed injections on June 10, 2011 that significantly exacerbated his pain to the point where he needed to increase his medication and temporarily had to restart Tramadol. Overall, he had three days of 40% or less pain relief and further injections were denied. On physical examination it was only noted that muscle bulk and tone in the bilateral lower extremities was normal and there was no decreased range of motion. Dr. recommended a spinal cord stimulator and changing from a short-acting Hydrocodone to long-acting Hydrocodone.

On November 1, 2011, the claimant was re-evaluated by MD who reported he did receive a transforaminal epidural steroid injection performed bilaterally at L5 level. It was also reported, that although the claimant only received 40% symptom relief from the intraarticular facet joint injection, that was the one procedure that provided significant amount of functional, as well as symptom improvement. On physical examination there was localized lumbosacral paraspinal muscle tenderness to palpation, as well as localized facet joint tenderness to palpation at approximately L5-S1 level. No SI joint or gluteal muscle tenderness to palpation bilaterally. Dr. recommended further diagnostic testing with bilateral L4, L5, S1 medial branch blocks.

On November 14, 2011, MD performed a UR on the claimant. Rationale for Denial: Given the patient has had a prior facet joint injection, it is presumed this patient has been shown to be unresponsive to conservative care, and his midline scar is not secondary to a lumbar fusion at the level in question; however, there is no documentation of such. Physical exam is noted to be brief and does not clearly eliminate signs of radiculopathy. This patient's prior bilateral facet injection at the L5-S1 afforded him with a 40% improvement in his pain lasting only 3 days. Official Disability Guidelines specify 50% relief for at least 6 weeks before proceeding to a medial branch block. Further, there is no evidence of a formal treatment plan to include other evidence based conservative care (activity, exercise, etc.) with the proposed medial branch block to facilitate functional improvement. As such, the request for bilateral L4-S1 medial branch block is not supported and is non-certified.

On December 5, 2011, Dr. wrote an appeals letter indicating that the claimant noted on his report only 40% symptom relief following the previous bilateral facet joint injections, however after further evaluation, the claimant not3ed that he was able to resume some activities of daily living, which he had been limited in significantly prior to the injection. It was also reported that he had been unable to participate in physical therapy secondary to significant increased pain limiting ability to ambulate or stand for extended periods of time. The claimant has been found not to be a surgical candidate and did not receive symptom relief from a bilateral L5 transforaminal epidural steroid injection. Dr. stated,

"Because of the significant limitations, minimal response to epidural steroid injection, and most profound results to facet joint injections, we are requesting that we can proceed on with diagnostic medial branch blocks to assess whether pain is originating from posterior elements and if positive result if we could proceed with radiofrequency themocoagulation for longer-term symptom improvement. The patient is not currently scheduled for any formal physical therapy in conjunction with these diagnostic blocks, as the patient is significantly limited in any type of activities."

On December 15, 2011, MD performed a UR on the claimant. Rationale for Denial: At the present time, for the described medical situation, this specific request would not be supported per criteria set forth by Official Disability Guidelines. There was an insufficient response to a previous attempt at treatment in the form of lumbar facet injections to support this request to be one of medical necessity.

On January 17, 2012, the claimant was re-evaluated by MD who continued to recommend lumbar medial branch blocks and was awaiting a Designated Doctor Report. If denial of the blocks continues, then she would consider a work-hardening program for the claimant.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:
Denial of Bilat L4-5-S1 medial branch block facet #1 64493 x 2/ 64494 x 2/ 64495 x2 77003-99144 to complete by 12-24-12 is upheld/agreed upon since several ODG and clinical criteria are not met: 1) There is history of previous fusion. 2) There are radicular symptoms. 3) Previous intraarticular injections were not successful since there was less than 70% initial relief for a duration of less than 6 weeks. 4) There is no formal plan of additional activity and exercise in addition to the facet joint injection.

ODG:
Facet joint medial branch blocks:

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).

Criteria for use of therapeutic intra-articular and medial branch blocks, are as follows:

1. No more than one therapeutic intra-articular block is recommended.
2. There should be no evidence of radicular pain, spinal stenosis, or previous fusion.
3. If successful (initial pain relief of 70%, plus pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive).
4. No more than 2 joint levels may be blocked at any one time.
5. There should be evidence of a formal plan of additional evidence-based activity and exercise in addition to facet joint injection therapy.

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)**