

MATUTECH, INC.

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Notice of Independent Review Decision

DATE OF REVIEW: January 30, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar median branch blocks right L2, L3, L4, L5 with CPT codes 64494 and 64495 and MAC anesthesia

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 by The American Board in Anesthesiology with certificate of added qualifications in pain medicine. This physician reviewer has over 24 years of active and current practice in the specialty of pain management.

REVIEW OUTCOME

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

Upheld (Agree)

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

INFORMATION PROVIDED TO THE IRO FOR REVIEW

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- Diagnostic (04/06/11)
- Office visits (06/28/11 – 12/27/11)
- Procedures (07/22/11 – 11/23/11)
- Utilization reviews (01/06/12)

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- Procedures (07/22/11 – 11/23/11)
- Office visits (09/13/11 – 12/05/11)
- Utilization reviews (12/13/11 – 01/06/12)

TDI:

- Utilization reviews (12/13/11 – 01/06/12)

ODG has been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

This claimant was allegedly initially injured on xx/xx/xx, while doing his normal job duties. He stopped himself from falling, wrenching his back. He went back to work after initial treatment, and sustained a re-injury of his low back on xx/xx/xx, again straining his back.

Lumbar MRI on April 6, 2011, was performed through the claimant's complaint of stabbing pain to the RIGHT leg. The MRI demonstrated a LEFT L3-L4 disc bulge and mild posterior disc bulges at L4-L5 and L5-S1. The claimant was seen by Dr. on June 28, 2011, with a pain level of 4/10, complaining of RIGHT lumbar pain radiating into the RIGHT buttock and upper portion of the posterior and lateral RIGHT thigh. It should be remembered here that the MRI findings were positive on the LEFT. Dr. noted that the claimant had returned to work after his initial injury of xx/xx/xx, but sustained a non-specified "re-injury event" on xx/xx/xx. He noted that the claimant's symptoms were more severe, but the symptom distribution was unchanged. The claimant complained of dull aching pain and occasional "catches" in the right lower back region. He also complained of pain into the upper lateral portion of the right thigh. He denied numbness, tingling or weakness. Dr. reviewed the lumbar MRI, quoting the results of the MRI in total, including the LEFT L3-L4 disc protrusion. Dr. noted there was no mention on the MRI of any facet joint pathology. Dr. reviewed the MRI noting some degree of hypertrophy in the facet joints and some facet sclerosis that he stated was "probably longer standing than the injury itself." He saw no obvious facet inflammation. Physical exam documented tenderness over the right lower back "particularly over the L4-L5 and L5-S1 facet joints." Neurological exam was entirely normal. Dr. diagnosed the claimant with a facet joint sprain and recommended L4-L5 and L5-S1 right facet joint injection. Dr. followed up with the claimant on July 18, 2011, noting his pain level had decreased to a level of 3. He also noted that the claimant was only authorized to have two facet joints injected at a time according to the ODG treatment guidelines. No physical exam was performed. On July 22, 2011, Dr. performed right L4-L5 and L5-S1 intra-articular facet joint injections. He followed up with the claimant two weeks later noting a pain level decreased from three to two. He stated that the claimant had approximately 80-85% reduction of pain for a few hours after the procedure followed by partial pain return. He noted the claimant still complained of "knifing" pain, a little higher in the back than it was before the injections. Dr. followed up with the claimant again four weeks later, six weeks after the injection, on September 8, 2011, noting his pain level of 7, which was worse than it had ever been. Dr. recommended re-injecting the previous facet joints and adding the L3-L4 joint. Physical exam document "facet features" over the right L4-L5 and L5-S1 facet joints and "subtle L3-L4 findings on the right." Five day later, the claimant was seen by Dr., who noted the claimant having an exacerbation of "pain radiating down his RIGHT leg." Again, it must be remembered that the MRI findings were solely on the LEFT. No physical exam was performed by Dr.. Dr. reevaluated the claimant four weeks later on October 4, 2011. No physical exam or pain level was documented. The claimant returned to Dr. on October 18, 2011, with a still increased pain level of 5/10. No physical exam was performed. The claimant again followed up with Dr. on November 1, 2011, still with an increased pain level of 5/10, worse than it was initially. Dr. noted ODG treatment guidelines that did not allow repeating facet joints without a "much longer

therapeutic response than what Mr. enjoyed.” He still recommended repeating the two previous facet joint injections as well as adding the L3-L4 level. No physical exam was documented.

On November 11, 2011, Dr. request was denied, but allowed for a single right L3-L4 facet joint injection. The reviewer cited ODG guidelines and the criteria that no more than one intra-articular block be performed and, if successful (producing initially 70% relief plus pain relief of at least 50% for at least six weeks) then a medial branch block should be done. Therefore the reviewer stated facet injections at L4-L5 and L5-S1 would not be indicated.

On November 23, 2011, Dr. performed right L3-L4 intra-articular facet joint injection. He followed up with the claimant two weeks later, documenting that his pain level had increased to a level of 6/10. However, despite that increase, he stated that the claimant reported a “modestly improved” pain by “roughly 25%.” Truly, the reported pain level and Dr. analysis of that pain level are contradictory. Physical exam documented residual L4-L5 and L5-S1 symptoms. Dr. now recommended L2 through L5 medial branch blocks on the right.

Initial review by a physician advisor on December 13, 2011, recommended against authorization of that request citing ODG treatment guidelines and the fact that the claimant had previously undergone facet injections providing only 25% relief. Dr. followed up with the claimant on December 27, 2011, noting his still increased pain level of 5/10. No physical exam was documented. Dr. then apparently appealed the denial, leading to a second physician advisor review on January 6, 2012, which also recommended against authorization of the requested right L2, L3, L4 and L5 medial branch blocks. That reviewer also cited ODG guidelines as well as the clinical results of the intra-articular injections that had already been performed; specifically, it pointed out the minimal relief following right L4, L3-L4 facet joint injection and the lack of documentation of significant sustained relief following the L4-L5 and L5-S1 facet joint injections.

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

The claimant has intermittently complained of radicular pain into his RIGHT leg. Despite the fact that the only MRI finding was of a LEFT L3-L4 protrusion, which could not, by any recognized medical mechanism, cause RIGHT leg symptoms. Additionally, the MRI, as noted by Dr., documented evidence of pre-existing facet joint degeneration, though no evidence of active inflammation. Therefore, the claimant’s alleged evidence of lumbar spondylosis is documented as being a pre-existing degenerative ordinary disease of life condition. The claimant then had right L4-L5 and L5-S1 facet joint injections which did not provide the degree or duration of relief cited in ODG treatment guidelines as being necessary to justify performing diagnostic medial branch blocks at those levels. Additionally, the claimant then had a right L3-L4 facet joint injection which provided him with only 25% relief for no sustained period of time. Therefore, according to ODG treatment guidelines, this claimant is not an appropriate candidate for medial branch blocks as none of the intra-articular facet joint injections provided the degree and/or duration of relief necessary to support medial branch blocks according to ODG. Additionally, given the claimant’s intermittent complaints of the RIGHT leg pain, despite there being MRI evidence of only a LEFT disc

protrusion, there is clearly significant concern regarding the validity of the claimant's subjective complaints. Finally, it is documented by Dr., himself that his interpretation of the MRI demonstrating evidence of facet joint degeneration is of a clearly pre-existing and ordinary disease of life condition. Therefore, for all of the above reasons, the requested right L2, L3, L4 and L5 medial branch blocks with MAC anesthesia are not medically reasonable or necessary, nor supported by ODG treatment guidelines. Additionally, the request for four-level block exceeds ODG recommendations for performing no more than three such medial branch blocks, blocking two levels of facet joints. The recommendations for non-authorization of the request are, therefore, upheld.

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

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**