

CASEREVIEW

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Notice of Independent Review Decision

DATE OF REVIEW: December 23, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient medial branch blocks at right L5-S3

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:

01/02/08: CT of the lumbar spine without contrast interpreted by

01/02/08: X-rays of the lumbar spine interpreted by

03/01/11: Evaluation by

04/26/11: Follow-up evaluation by

05/26/11: Follow-up evaluation by

06/23/11: Follow-up evaluation by

07/18/11: Follow-up evaluation by

09/30/11: Follow-up evaluation by

10/26/11: UR performed by

11/07/11: Follow-up evaluation by

11/21/11: UR performed by

12/05/11: Follow-up evaluation by

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant slipped on ice causing her to fall and injure her neck and back on xx/xx/xx. She underwent four lumbar surgeries including 360 degree fusion.

On January 2, 2008, CT of the lumbar spine without contrast revealed: 1. Anterior interbody fusions with ventral L5 buttressing screw and bilateral L4, L5, and S1 pedicle screws and rods appearing well positioned. 2. Facet arthropathy at both L4-5 and L5-S1. Graft material appears well positioned at both levels. 3. No other lumbar spine abnormality is seen.

On January 2, 2008, X-rays of the lumbar spine revealed: 1. Postoperative changes with posterior fusion of L4-S1. No retrolisthesis or anterolisthesis noted. 2. Suggestion of minimal lumbar scoliosis with convexity to the left.

On March 1, 2011, the claimant was evaluated by who noted she had a history of low back surgery syndrome status post L4 through S1 fusion and also had chronic lumbosacral radiculitis status post spinal cord stimulator placement. He also noted she seemed to have probable right sacroiliac joint dysfunction. Current medications were Methadone 10 mg three times a day, Norco 10/325 three to four per day, Cymbalta 30 mg, Wellbutrin XL 150 mg, Neurontin 300 mg, and Skelaxin 800 mg twice a day. On physical examination seated straight leg raise was negative bilaterally. Muscle testing was 5/5. There was right GT tenderness to palpation and right sacroiliac joint tenderness to palpation. FABER was slightly positive on the right for low back pain. discontinued Skelaxin and changed it to Robaxin 750 mg. She was continued on Methadone 10 mg, Norco 10/325, Cymbalta 30 mg, and Wellbutrin XL 150 mg and Neurontin 300 mg.

On June 23, 2011, the claimant was re-evaluated by who noted she continued to complain of some right greater than left SI joint pain. On examination there was tenderness to palpation of both the right and left SI joint region. recommended bilateral SI joint injection to address the SI joint dysfunction. She was also prescribed Ambien.

On July 18, 2011, the claimant was re-evaluated by who noted the SI joint injections were denied. He continued to recommend the bilateral SI joint injections.

On September 30, 2011, the claimant was re-evaluated by who reported she was post bilateral SI joint injections on 09/16/11 and had pain that was constant throbbing with intermittent burning in low back with right greater than left and radiation on right into buttock and thigh. She indicated the pain was worse after the injection. He did report that the day following the injection she had o SI pain and that the left is still much better than the right. On examination Faber's was very positive for right sided LBP and there was tenderness to palpation of the right SI joint. recommended right L5-S3 MBBs performed under fluoroscopy.

On October 26, 2011, performed a UR on the claimant. Rationale for Denial: The request as written is not medically reasonable and necessary and therefore is not authorized. There is no recent documentation presented that the claimant has facet mediated/MMB pain in these areas.

On November 7, 2011, the claimant was re-evaluated by who on examination found tenderness over right SI joint. Faber's was positive for right LBP. Seated straight leg raise was positive on the left. Sensation exam was normal. recommended right L5 dorsal ramus and S1-3 lateral branch blocks and stated he would also consider right SI joint radiofrequency ablation.

On November 21, 2011, performed a UR on the claimant. Rationale for Denial: The claimant has a spinal cord stimulator implanted and is post-bilateral SI joint injections. The submitted 11/11/11 physical examination findings indicate no focal neurologic deficit. There is right-sided SI joint tenderness to palpation and positive FABER test for right LBP. The requested fluoroscopic right L5-S3 medial branch blocks (dorsal rami) is not approved because the sacrum is fused and there is no anatomic facet joint pain generator identified that would benefit from this type of invasive procedure.

On December 5, 2011, the claimant was re-evaluated by who noted that she is definitely set up for SI joint pain because the hardware placement to S1 causes increased force to be distributed to the Si joints. She had a very provocative examination for right SI joint pain and had significant pain with sitting in the right gluteal region. There was no ishial ttp. She has problems with walking secondary to this right gluteal/sacral pain. noted he submitted for diagnostic right L5-S3 branch blocks to see if she is a candidate for RF and indicated that it would actually be L5 dorsal ramus block and S1-3 lateral branch blocks.

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

Denial of medial Branch Blocks at right L5 to S3 is upheld. ODG Low Back chapter criteria are not met. Submitted clinical do not support facet joints as origin of pain, medial branch blocks are not recommended in cases of previous fusion, and no more than two joint levels may be blocked at any one time.

ODG:

Facet joint diagnostic blocks (injections)	Recommend no more than one set of medial branch diagnostic blocks prior to facet neurotomy, if neurotomy is chosen as an option for treatment (a procedure that is still considered "under study"). Diagnostic blocks may be performed with the anticipation that if successful, treatment may proceed to facet neurotomy at the diagnosed levels. Current research indicates that a minimum of one diagnostic block be performed prior to a neurotomy, and that this be a medial branch block (MBB). Although it is suggested that MBBs and intra-articular blocks appear to provide comparable diagnostic information, the results of placebo-controlled trials of neurotomy found better predictive effect with diagnostic MBBs. In addition, the same nerves are tested with the MBB as are treated with the neurotomy. The use of a confirmatory block has been strongly suggested due to the high rate of false positives with single blocks (range of 25% to 40%) but this does not
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appear to be cost effective or to prevent the incidence of false positive response to the neurotomy procedure itself. ([Cohen, 2007](#)) ([Bogduk, 2000](#)) ([Cohen2, 2007](#)) ([Manchukonda, 2007](#)) ([Dreyfuss, 2000](#)) ([Manchikanti2, 2003](#)) ([Datta, 2009](#))

Etiology of false positive blocks: Placebo response (18-32%), use of sedation, liberal use of local anesthetic, and spread of injectate to other pain generators. The concomitant use of sedative during the block can also interfere with an accurate diagnosis. ([Cohen, 2007](#))

MBB procedure: The technique for medial branch blocks in the lumbar region requires a block of 2 medial branch nerves (MBN). The recommendation is the following: (1) L1-L2 (T12 and L1 MBN); (2) L2-L3 (L1 and L2 MBN); (3) L3-L4 (L2 and L3 MBN); (4) L4-L5 (L3 and L4 MBN); (5) L5-S1: the L4 and L5 MBN are blocked, and it is recommended that S1 nerve be blocked at the superior articular process. Blocking two joints such as L3-4 and L4-5 will require blocks of three nerves (L2, L3 and L4). Blocking L4-5 and L5-S1 will require blocks of L3, L4, L5 with the option of blocking S1. ([Clemans, 2005](#)) The volume of injectate for diagnostic medial branch blocks must be kept to a minimum (a trace amount of contrast with no more than 0.5 cc of injectate), as increased volume may anesthetize other potential areas of pain generation and confound the ability of the block to accurately diagnose facet pathology. Specifically, the concern is that the lateral and intermediate branches will be blocked; nerves that innervate the paraspinal muscles and fascia, ligaments, sacroiliac joints and skin. ([Cohen, 2007](#)) Intraarticular blocks also have limitations due to the fact that they can be technically challenging, and if the joint capsule ruptures, injectate may diffuse to the epidural space, intervertebral foramen, ligamentum flavum and paraspinal musculature. ([Cohen, 2007](#)) ([Washington, 2005](#)) ([Manchikanti, 2003](#)) ([Dreyfuss, 2003](#)) ([BlueCross BlueShield, 2004](#)) ([Pneumaticos, 2006](#)) ([Boswell, 2007](#)) ([Boswell2, 2007](#)) A recent meta-analysis concluded that there is insufficient evidence to evaluate validity or utility of diagnostic selective nerve root block, intra-articular facet joint block, medial branch block, or sacroiliac joint block as diagnostic procedures for low back pain with or without radiculopathy. ([Chou2, 2009](#)) This study suggests that proceeding to radiofrequency denervation without a diagnostic block is the most cost-effective treatment paradigm, but does not result in the best pain outcomes. ([Cohen, 2010](#)) See also [Facet joint pain, signs & symptoms](#); [Facet joint radiofrequency neurotomy](#); [Facet joint medial branch blocks](#) (therapeutic injections); & [Facet joint intra-articular injections](#) (therapeutic blocks). Also see [Neck Chapter](#) and [Pain Chapter](#).

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.
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.
4. No more than 2 facet joint levels are injected in one session (see above for medial branch block 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. ([Resnick, 2005](#))
11. Diagnostic facet blocks should not be performed in patients who have had a previous

	fusion procedure at the planned injection level. [Exclusion Criteria that would require UR physician review: Previous fusion at the targeted level. (Franklin, 2008)]
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<p>Facet joint medial branch blocks (therapeutic injections)</p>	<p>Not recommended except as a diagnostic tool. Minimal evidence for treatment.</p> <p><i>Pain Physician 2005:</i> In 2005 <i>Pain Physician</i> 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 than 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 <i>Pain Physician</i>.] The average relief per procedure was 11.9 ± 3.7 weeks.</p> <p><i>Pain Physician 2007:</i> 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).</p>
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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)**