

MEDRx

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Notice of Independent Review Decision

DATE OF REVIEW: 6/28/12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of Medial Branch Block at the left L3-L4, L4-L5, and L5-S1 under Fluoroscopic Guidance between 6/5/12 and 8/4/12.

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

The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation.

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)

The reviewer disagrees with the previous adverse determination regarding the prospective medical necessity of Medial Branch Block at the left L3-L4, L4-L5, and L5-S1 under Fluoroscopic Guidance between 6/5/12 and 8/4/12.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:

Utilization Review

These records consist of the following (duplicate records are only listed from one source):

Records reviewed from ESIS Utilization Review

Health Solutions

Denial- 6/12/12, 5/30/12

M.D.

Office Notes- 5/14/12, 5/8/12

Preauthorization- 2/24/12, 5/30/12

M.D., FAADEP

Summary of Medical Records- 1/27/12

TWC

MMI- 4/22/09

Direct Rehab Med

Impairment Rating- 4/22/09

Records reviewed from M.D.

D.O.

Office Notes- 4/11/11, 10/10/11, 12/22/11, 2/7/12, 3/29/12, 5/2/12, 5/8/12, 6/12/12

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

Worker sustained multiple injuries xx/xx/xx while employed. He went to surgery for exploratory laparotomy and diverting colostomy, closure of the right thigh degloving wound, closure of a wound to the left knee and joint capsule, closure of a full thickness rectal wall laceration, closure of a complex anal laceration, closed manipulation and percutaneous screw fixation of posterior pelvic ring fractures, closed reduction and external fixation of bilateral pubic ramus fractures. Weight-bearing was permitted in March 2008 after removal of the external fixation hardware. The severe wounds required extensive treatment including hyperbaric oxygen, incision and drainage, placement of a wound VAC, surgical debridement procedures, and split thickness skin grafting. Further surgery was required for colostomy reversal and subsequently for treatment of small bowel obstruction. Rehabilitation included physical therapy and work hardening.

On 4/22/2009 the worker received an 18 percent whole person impairment rating with diagnosis codes 808.0, 890.2, and 863.9. Five percent of the impairment was for the lumbosacral spine and 3 percent for the sacroiliac joint fractures.

On the 4/11/2011 outpatient evaluation by Dr., the worker complained of constant pain in the lumbar area. Examination revealed abnormal motion of the thoracic spine and lumbar spine, loss of the normal lumbar lordosis, tenderness to palpation over the lumbosacral spine, sacrum and coccyx, muscle spasms over the lumbosacral spine, pain-limited hip weakness. Knee and ankle reflexes were reported to be normal. Pertaining to the lower back, the diagnosis was lumbar disc degeneration and lumbar facet syndrome. The worker was treated with an intramuscular steroid injection and was given a prescription for Lortab. The worker was released to work with permanent restrictions to light duty.

On the outpatient visit, 12/22/2011, the worker reported increasing pain in the right hip joint and gluteal area, relieved by rest. His medications were Vicodin and Flexeril. Lower back examination was as noted above. There was tenderness in the right hip joint without crepitus or instability and tenderness to palpation over the right gluteal mass. Treatment included intramuscular injection of steroids and prescriptions for Lortab, Flexeril and for Celebrex 200 milligrams daily for 30 days. Follow-up in six months was requested.

On 01/27/2012 a peer review was performed by M.D., who agreed that maintenance medication for pain management is appropriate and reasonable.

On a follow-up visit 2/7/2012 the worker reported that nothing helped the pain. He was working light duty. Examination revealed evidence of cellulitis/abscess at the margin of the skin graft on the right posterior thigh. Prescriptions were given for clindamycin and Bactrim DS. On 3/29/2012 the worker reported constant pain. He was not working. Dr. examined the

worker and diagnosed posttraumatic osteoarthritis of the hip, lumbar disc degeneration, lumbar facet syndrome. Treatment included intramuscular steroid injection, prescriptions for Lortab, Celebrex, and Flexeril.

On 5/2/2012 the worker reported a pain level of 8/9 and he was not working. His medications were Vicodin ES 750/7.5, Celebrex 200 milligrams twice daily, and Flexeril five milligrams twice daily. Musculoskeletal examination revealed abnormal motion of the thoracic and lumbar spine, tenderness to palpation of the lumbar spinous process, tenderness to palpation over the sacrum most pronounced over the right SI joint. Straight leg raising was negative bilaterally. X-ray of the pelvis was reported to show abnormal tilting of the right ilium. X-ray of the right hip was reported to show mild osteoarthritis of the right acetabulum. Dr. diagnosed osteoarthritis of the hip post traumatic, sacroiliitis, lumbar disc degeneration, lumbar facet syndrome. Treatment included prescription refills, prescription for Lidoderm transdermal patches, consultation with a specialist Dr., and no return to work.

On 5/8/2012 the worker complained of constant right hand and right hip pain after falling. He was not working. Examination revealed tenderness around the MCP joint of the right middle finger, with painful range of motion. There was a contusion and mild swelling over the right hip, with an antalgic gait. Thoracolumbar and lumbosacral spine examination was again abnormal, as noted above.

Dr. saw the worker in consultation on 5/14/2012. The worker reported excruciating pain in the lower back radiating to the left buttock, worse with sitting, driving, standing, walking, stooping, bending. Pain was relieved by lying down, by frequent position changes while sitting, and by medications. Pain interfered with sleep. No lower back pain radiated to the groin, anterior thigh, knee, legs, ankle, foot or toes.

There was no shock like sensation in the lower back, no muscle spasms, no urinary urgency, no urinary loss of control. On the musculoskeletal system physical examination there was no tenderness or muscle spasm over the thoracic spine. Thoracolumbar spine range of motion was abnormal. There was a large defect of the right buttock and lateral thigh. There was tenderness to palpation over the transverse processes in the left lower lumbar spine but not on the right. A lumbar extension test was positive. There was no tenderness to palpation over the lumbar spinous processes, sacral promontory or coccyx. Straight leg raising was negative. The gait was reported to be antalgic. Knee and ankle reflexes were reported to be normal. Dr. Prasad noted that there was severe left lower lumbar Z joint mediated pain with no evidence of radiculopathy on prior MRI and CT scans. The antalgic gait pattern was attributed to the history of pelvic ring fracture. Dr. recommended diagnostic left L3-S1 medial branch blocks with Marcaine. If favorable results were obtained he would consider RF neurotomy. He advised the worker to continue the current medications and to remain off work.

On 5/30/2012 the requested medial branch blocks were non-certified. On 6/12/2012 Dr. advised the worker to continue current medications, follow-up re-examination in six months, and "Not fit for work, off for now." On June 12, 2012 the requested procedure was non-certified on appeal.

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

Recommended approval for requested services. Based on the records submitted for review, the requested procedure is recommended at this time.

Pertaining to the lower back pain, the recorded subjective complaints and physical findings are consistent with a diagnosis of “facet mediated” pain as discussed in the ODG Integrated Treatment/Disability Duration Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic) (updated 05/29/12), regarding facet joint pain, signs & symptoms

- There is no reliable pain referral pattern, but it is suggested that pain from upper facet joints tends to extend to the flank, hip and upper lateral thighs, while the lower joint mediated pain tends to penetrate deeper into the thigh (generally lateral and posterior). Infrequently, pain may radiate into the lateral leg or even more rarely into the foot. In the presence of osteophytes, synovial cysts or facet hypertrophy, radiculopathy may also be present.
- Recent research has corroborated that pain on extension and/or rotation (facet loading) is a predictor of poor results from neurotomy. ([Cohen2, 2007](#)) The condition has been described as both acute and chronic. ([Resnick, 2005](#))
- Studies have been conflicting in regards to CT and/or MRI evidence of lumbar facet disease and response to diagnostic blocks or neurotomy.
- Suggested indicators of pain related to facet joint pathology (acknowledging the contradictory findings in current research):
 1. Tenderness to palpation in the paravertebral areas (over the facet region);
 2. A normal sensory examination;
 3. Absence of radicular findings, although pain may radiate below the knee;
 4. Normal straight leg raising exam.
 5. Indictors 2-4 may be present if there is evidence of hypertrophy encroaching on the neural foramen.

The requested procedure falls within the ODG Integrated Treatment/Disability Duration Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic) (updated 05/29/12), pertaining to Facet joint diagnostic blocks (injections).

- Diagnostic blocks may be performed with the anticipation that if successful, treatment may proceed to facet neurotomy at the diagnosed levels.
- 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.
- Criteria for the use of diagnostic blocks for facet “mediated” pain:
 1. Clinical presentation should be consistent with [facet joint pain, signs & symptoms](#).
 2. 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.
 3. Limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally. [Note: the 2 levels are L4-5 and L5-S1. As noted in the underlined text above, blocking L4-5 and L5-S1 will require blocks of L3, L4, L5 with the option of blocking S1].

4. There is documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks.
5. No more than 2 facet joint levels are injected in one session (see above for medial branch block levels).
6. Recommended volume of no more than 0.5 cc of injectate is given to each joint.
7. 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.
8. Opioids should not be given as a “sedative” during the procedure.
9. 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.
10. 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.
11. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated. ([Resnick, 2005](#))
12. 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](#))]

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)