

CASEREVIEW

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Notice of Independent Review Decision

DATE OF REVIEW: May 13, 2012, Amended May 16, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

ASC Medial Branch Block Injection Right L4-5 L5-S1 64493 64494

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

This physician is Board Certified by American Board of Orthopedic Surgeons with over 40 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:

07/20/11: Handwritten Progress Note, author unknown
07/27/11: Handwritten Progress Note, author unknown
08/10/11: Handwritten Progress Note, author unknown
08/22/11: Handwritten Progress Note, author unknown
09/02/11: Handwritten Progress Note, author unknown
09/02/11: X-rays of the Lumbar Spine ordered by and interpreted by
09/12/11: Handwritten Progress Note, author unknown
09/12/11: X-rays of the Left Shoulder ordered by and interpreted by: Physical Therapy
Daily/Weekly Progress Notes
09/15/11 – 11/28/11: Physical Therapy Progress Notes
09/26/11: Handwritten Progress Note, author unknown
10/10/11: Handwritten Progress Note, author unknown

10/19/11: MRI Lumbar Spine w/o Contrast interpreted by
10/24/11: Handwritten Progress Note, author unknown
11/18/11: Handwritten Progress Note, author unknown
12/21/11: Handwritten Progress Note, author unknown
01/13/12: Report of Medical Evaluation by, a Designated Doctor
02/29/12: Follow-up Evaluation by
02/29/12: AP, Flexion and Extension Lateral Views of the Cervical Spine interpreted by
02/29/12: AP and Lateral Views of the Thoracic Spine interpreted by
02/29/12: AP, Flexion and Extension Lateral Views of the Lumbar Spine interpreted by
04/02/12: UR performed by
04/17/12: UR performed by

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who was injured on xx/xx/xx. Her right foot slipped causing her to fall backwards on her back and left shoulder.

On July 20, 2011, the handwritten progress note indicated that the claimant presented with complaints of back pain, left shoulder pain and neck pain. Diagnosis: Cervical sprain/strain and Thoracic strain/contusion. Plan: Naproxen, Tramadol, and Flexeril.

On July 27, 2011, the handwritten progress note indicated that the medications were helping with the pain, but that she was having "tingling" that went down her back. It was recommended she continue medication.

On August 10, 2011, the handwritten progress note indicated that the claimant denied any neck and shoulder pain and she was ready to be released. She was returned to work without restrictions.

On August 22, 2011, the handwritten progress note indicated that the claimant continued to deny shoulder/neck pain, but after returning to work with no restrictions she started having low back pain. X-rays of the back were ordered and she was prescribed Naproxen and Flexeril.

On September 2, 2012, X-rays of the Lumbar spine, Impression: No acute bony trauma. Facet arthritis as described above. (Arthritis is noted in the facet joints bilaterally at L5/S1. Lesser changes of arthritis are noted in the facet joints at L4/5.)

On September 12, 2011, the handwritten progress note indicated the claimant had complaints of low back pain and left shoulder pain. Plan: X-rays of the left shoulder and physical therapy. Continue Naproxen and Flexeril.

On October 11, 2011, the handwritten progress note indicated that the claimant finished therapy for her lower back which was reported to have been helping her. Diagnosis: 1. Low back pain with radiculopathy. 2. Left shoulder pain. 3. Consider SI joint

dysfunction. Plan: MRI of the lumbar, continue physical therapy, continue Naproxen, Skelaxin and Ultram.

On October 19, 2011, MRI of the Lumbar Spine, Impression: 1. No acute osseous abnormality. 2. Facet arthrosis at the L5-S1 level, left greater than right. 3. Small posterior central disk protrusion at T12-L1 but no foraminal stenosis.

On December 21, 2011, the handwritten progress note indicated that the claimant continued to have lower back/hip pain and PT helped a little bit. The claimant was finished with therapy. Plan: Refer to TBI for chronic low back pain, continue Ultram, Naproxen, and Flexeril, and continue home therapy.

On January 13, 2012, the claimant was evaluated by a designated doctor. opined that the claimant had reached clinical MMI as of November 21, 2011 with a 7% whole person impairment. physical examination revealed tenderness to left C4-C7 and bilateral L1-S1 with left greater than right. No muscle spasm was present. Kernig/Brudzinski was negative. Left supine straight leg raise was measured at 52 degrees. Right supine straight leg raise was measured at 50 degrees. Sitting root test was negative. FABER was positive left. Babinski test was negative. Range of motion of the lumbar spine was decreased to left lateral flexion and left rotation. Spinal dermatome testing shows hypersensitivity to left L3 and left L4 dermatomes. Lower extremity deep tendon reflexes were 2/2 bilaterally. No atrophy was found. Sensation of the lower extremities showed hypersensitivity to left saphenous nerve. Lower extremity muscle testing was +5 for all muscle groups bilaterally. opined that the claimant reached MMI effective the date of his last visit with her treating doctor on 11/21/11. opined that the MRI of the lumbar spine did not show significant findings to support the need for further active medical treatment or surgical intervention.

On February 29, 2012, the claimant had a follow-up evaluation with who reported she had significant lower back and flank pain, as well as lower groin pain or rather right lower facet pain. Pain in the back was significant. Physical therapy was reported to improve it. On physical examination she had relatively good motor function with 5/5 strength in the iliopsoas, quads, tib ant, EHL, and gastrocsoleus. On focal palpation, she was point tender on the facets, especially on the right 4-5 and 5-1 facets. Assessment: Sprain along with facet mediated inflammation at 4-5 and 5-1. recommended a medial branch block at the segments of 4-5 and 5-1.

On February 29, 2012, X-rays of the Lumbar Spine, Impression: 1. Mild anterior wedging of L1 vertebra. 2. On the extension view, there is a 3.5 mm anterolisthesis of L5 on S1, which was reduced to 1.2 mm on the flexion view. 3. Narrowing of the L5-S1 disc space.

On April 2, 2012, performed a UR on the claimant. Rationale for Denial: As per 2/29/12 report, the patient presents with low back and right-sided flank and groin pain. The physical examination reveals point tenderness at the right L4-5 and L5-S1 facets. Motor strength in the iliopsoas, quadriceps, tibialis anterior, extensor hallucis longus and

gastrocsoleus is 5/5. Sensory and reflex exam findings were not noted. Lumbar MRI and x-rays showed facet arthrosis at L4-5 and L5-S1. The patient has undergone Physical Therapy with noted improvement in active range of motion, although with some remaining limitation on flexion per 11/1/11 PT progress note. This is a request for right L4-5 and L5-S1 Medial Branch Block. A recent comprehensive physical examination of the lumbar spine and lower extremities from the requesting provider was not submitted for review. Medical records did not indicate objective findings that would rule out a radicular source of pain. Exhaustion and failure of response to other conservative treatment such as medications were not objectively documented. There was no formal plan specifying the use of the requested procedure as an adjunct to active rehabilitation activities. Plans for subsequent neurotomy were likewise not noted. Hence, the medical necessity of this request has not been substantiated.

On April 17, 2012, performed a UR on the claimant. Rationale for Denial: There remains no documentation of objective findings that would rule out a radicular source of pain, a formal plan specifying the use of the requested procedure as an adjunct to active rehabilitation activities, and plans for subsequent neurotomy. Therefore, the medical necessity of the request has not been substantiated.

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

The previous decisions are upheld. The October 19, 2011 MRI already showed that the claimant has said arthropathy. A medial branch block would not add to the diagnosis and certainly would not help with the treatment of her pain for any length of time. There was no plan submitted as to what subsequent treatment would be utilized as a result of the medial branch block. There is also a lack of documentation of failure of lower conservative care including home exercise program. In February 29, 2012 report, it was indicated the claimant had improvement in her pain with physical therapy. Therefore the request for ASC Medial Branch Block Injection Right L4-5 L5-S1 64493 64494 if found to not be medically necessary.

PER ODG GUIDELINES:

<p>Facet joint diagnostic blocks (injections)</p>	<p>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 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) <i>Etiology of false positive blocks:</i> Placebo response (18-32%), use of sedation, liberal use</p>
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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](#))]

<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)**