

Parker Healthcare Management Organization, Inc.

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Notice of Independent Review Decision

DATE OF REVIEW: APRIL 1, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed Lumbar facet block (64475) at the bilateral L3-L4 and L4-L5 under Anesthesia with fluoroscopic guidance

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Orthopedic surgery and is engaged in the full time practice of medicine.

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)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
722.10	64475		Prosp	1			Xx/xx/xx	C494C2816990	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI-HWCN-Request for an IRO-19 pages

Respondent records- a total of 113 pages of records received to include but not limited to: letter 2.12.13, 3.4.13; 3.4.13; records, 1.18.13; MRI Lumbar spine 9.1.12; EMG report 10.26.12; ODG Low back, Lumbar and Thoracic; records, 2.7.13-2.26.13; report, 9.10.12; TDI letter 3.11.13; request for an IRO forms

Requestor records- a total of 0 pages of records received to include but not limited to:

TDI Notice of assignment to PHMO 3.11.13; PHMO Request for records 3.11.13, 2nd Request for records 3.18.13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who was injured on xx/xx/xx, when a xx fell on him and he received a blow to the back.

A lumbar spine MRI was performed on September 1, 2012. The study documented:

1. At the L2-L3 level, there was posterior disc bulging measuring 2 mm producing effacement of the thecal sac and mild bilateral neural foraminal stenosis,
2. At the L3-L4 level, there was posterior disc bulging measuring 2 mm producing effacement of the thecal sac and mild bilateral neural foraminal stenosis,
3. At the L4-L5 level, there was posterior disc bulging measuring 2 mm producing effacement of the thecal sac, mild stenosis of the right lateral recess and mild bilateral neural foraminal stenosis,
4. At the L5-S1 level, there was posterior disc bulging measuring 1 mm producing effacement of the thecal sac and mild stenosis of the bilateral lateral recesses.

A peer review was performed on September 10, 2012. In this review, determined that no further treatment was reasonable or necessary as the medical records did not indicate further treatment in the form of documented objective residual of injury.

Electrodiagnostic testing was performed on October 26, 2012. The study documented findings consistent with a moderate to severe bilateral L5-S1 myopathy. No evidence of active denervation, chronic reinnervation, and reduce motor unit recruitment was noted.

The injured employee was evaluated on January 18, 2013. It was noted that a request for a lumbar epidural steroid injection had been denied. The injured employee continued to use hydrocodone, Flexeril, and Lunesta for symptom control. Participation in a chronic pain management program had been considered. The physical examination documented no gross deformity of the spine. Tenderness to palpation in the lower lumbar vertebral musculature of the left was noted. Straight leg raising produced back pain at 90°. The injured employee was independent with positional changes and was noted to be using a single point cane for ambulation with a slightly antalgic gait. Restricted range of motion of the lumbar spine was noted. The diagnoses made were lumbar disc displacement and backache. The continued use of medications was recommended.

A letter of medical necessity was prepared on February 7, 2013. It was noted that diagnostic bilateral lumbar facet blocks at L3, L4, and L5 had been requested due to axial back pain. Extensive physical therapy had failed to provide significant pain relief. The injections were needed to return the injured employee to gainful employment.

A non-certification of the requested injections was completed on February 12, 2013. The reviewer noted that no documentation of a response to a work hardening program had been provided. No indication was provided that a follow-up neurotomy was planned depending upon the efficacy of the injections. Additionally, the use of sedation may negate the result of the diagnostic injections.

prepared a letter of reconsideration February 26, 2013. It was noted that the injured employee suffered from axial pain with no evidence of radiculopathy. Rearward extension elicited pain. No response to physical therapy had been noted. And a medial facet rhizotomy was planned if a successful injection was obtained.

A subsequent non-certification of the requested procedure was prepared on March 4, 2013, noted that it was unclear if the injured employee was participating in a chronic pain management program or would continue with work hardening in conjunction with the facet injections. Insufficient evidence to overturn the previous non-certification was provided.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

RATIONALE:

As noted in the Division mandated Official Disability Guidelines Low Back Chapter (updated March 12, 2013), the use of diagnostic facet blocks is indicated when documentation of a failure of conservative treatment including home exercises, physical therapy, and nonsteroidal anti-inflammatory drugs has been provided. The requesting provider noted that physical therapy had not provided significant relief of symptoms; however, the failure of a home exercise program or nonsteroidal anti-inflammatory drugs other than Lodine was documented. The guidelines indicate that the clinical presentation should be consistent with facet joint pain, signs, and symptoms. The injured worker was thought to have signs of a radiculopathy and treatment was initially aimed at that diagnosis. No specific tests were shown to implicate the facet joints as the cause of pain, other than back extension caused pain. The guidelines also state that no more than two facet joint levels should be injected in one session and the provided request is for bilateral injections at three levels. Based on these factors, the request for bilateral diagnostic facet injections at L3, L4, and L5 is not supported.

Official Disability Guidelines Low Back (updated March 12, 2013)

Facet joint diagnostic blocks (injections)

Criteria for the use of diagnostic blocks for facet "mediated" pain:

Clinical presentation should be consistent with facet joint pain, signs, and symptoms.

1. One set of diagnostic medial branch blocks is required with a response of $\geq 70\%$. The pain response should last at least two 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 four to six weeks.
4. No more than two 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 four hours prior to the diagnostic block and for four to six 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)]

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
- XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- XX 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)