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Notice of Independent Review Decision

August 6, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right-sided facet block at L4-L5 and L5-S1

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

Board Certified Pain Management Physician

REVIEW OUTCOME:

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

X Upheld (Agree)

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

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Utilization reviews (07/02/13, 07/10/13)
- Office visits (12/11/08 – 06/25/13)
- Diagnostics (07/19/09 – 05/16/13)
- Diagnostic (07/19/09)
- Office visit (06/25/13)
- Utilization reviews (07/02/13, 07/10/13)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is female who on xx/xx/xx, was lifting a box overhead when she felt something rupture in her back.

There are no records available from xxxx through 2007.

On December 11, 2008, the patient was seen, for lumbar back pain, radiculopathy pain to the lower extremity and failed back surgery syndrome (FBSS). The patient was referred for minimally-invasive trial injections to improve pain. The patient complained of lumbar spine pain for more than six months, which was dull, aching, sharp, shooting in nature, aggravated with movement and relieved with rest. The pain was mild-to-moderate in nature. The pain radiated to the thigh and leg on the right side. The patient also complained of tingling/numbness mostly on the right side. It was noted that the patient had had physical therapy (PT) trials which did not help. The patient had undergone surgery x2 including laminectomy followed by fusion. She had pain to the right leg and right lateral calf. Examination of the lower extremity joints showed osteoarthritis of the knee with crepitation and popping. Examination of the lumbar spine showed tenderness from L2-L3 through L5-S1 bilaterally with decreased range of motion (ROM), facet tenderness, tenderness on the lower levels than upper level on the right side, tenderness on the left side, trigger points noted throughout the spine, provocation positive taut muscles bundles noted, spastic parathoracic, paralumbar, paragluteal musculature and spastic knots to the spine. There was a scar in the midline which was well-healed. There was sacroiliac (SI) joint tenderness with provocation positive on the right and manipulation, positive right Faber's, positive right pelvic rock test. There were gluteal spasms noted, piriformis muscle spasticity and positive Faber's on the right. There was GTTB bilateral tenderness, worse right than left referred to SI joint and gluteal referred to the legs. There was fascia lata positive tenderness on the right side. There was fibromyalgia. Diagnoses were lumbar and sacral spondylarthritis, radicular syndrome of lower limbs and sacroiliitis. The patient was utilizing meloxicam, Darvocet N and Zanaflex. The patient was advised on Tylenol/acetaminophen overuse, misuse or extra taking of Tylenol. reviewed medications given by the referring physician and primary care. The patient was counseled regarding that injury prevention and exercise. She was given Hyalgan information pamphlet. There was discussion regarding joint, ROM exercises, R&B for steroid intra-articular joint therapy, lumbar exercise information and instruction pamphlet and weight loss diet. The patient was to follow-up in two weeks.

On March 3, 2009, the patient was seen for chronic lumbar axial pain, lumbar back pain, lumbar radiculopathy, lumbar FBSS. opined that there was need for ROM muscle movement and strength objective testing to be evaluated as well as a magnetic resonance imaging (MRI) and electromyography (EMG) study to evaluate radicular pain versus musculoskeletal pain. The patient had lumbar pain mostly on the right side associated with severe spasms, worse with rotation and extension of the lumbar spine. The patient had pain, worse on the right side than the left, to the thigh and leg and tingling/numbness over L4 and L5 distribution. It was noted that the medications were helping to decrease pain and increase quality of life. CBC and CMP were to be ordered secondary to chronic medication use on routine quarterly basis.

On March 31, 2009, the patient was seen. Her pain level was 8/10. MRI was discussed. It was noted that the patient had exhausted all other treatments and

adjuvant therapies and desired to proceed with invasive therapy. She had radiculopathic pain extending laterally and recurrence of the radicular pain with exacerbation. She needed an LSO orthotic device for chronic recurrence spine pain and a transcutaneous electrical nerve stimulation (TENS) unit trial. The patient wore a large thoracolumbar brace. recommended Zanaflex trials to increase by one tablet t.i.d. dosing and adding one tablet q 3-7 days up to maximum 3 p.o. t.i.d. and Darvocet trial medication. EMG was needed to distinguish between entrapment and systematic neuropathy.

From April through June 2009, the patient had monthly follow-ups for radiculopathy pain to the lower extremities, chronic lumbar axial pain, lumbar back pain, lumbar radiculopathy and facet lumbar spondylitic pain, chronic in nature. The pain radiated through the thigh and leg on the left side and to the buttocks. assessed postlaminectomy syndrome of the lumbar region, chronic pain syndrome, radicular symptoms of the lower limbs, lumbar and sacral spondylarthritis. He recommended Mobic for joint pain, a trial of Darvocet and Zanaflex and use of adjunct cream mixture.

On July 17, 2009, the patient underwent EMG/nerve conduction velocity (NCV) study of the lower extremities which showed evidence of chronic bilateral L4 lumbar radiculopathy, evidence of mild bilateral peroneal mononeuropathy of uncertain etiology. There was clinical report of bilateral back pain, extremity pain bilaterally and extremity paresthesias bilaterally.

From July 28, 2009, through December 10, 2009, the patient had monthly follow-ups for complaints of chronic lumbar axial pain, lumbar back pain, lumbar radiculopathy pain to the lower extremities, lumbar FBSS, right leg pain, lumbar compression fracture pain, left facet pain, SI joint chronic pain and right facet pain. discussed MRI and EMG with the patient. The patient was to continue calcium supplementation and vitamin D, Darvocet trials and Zanaflex trials. recommended facet medial branch nerve (MBN) block at L4-L5 and L5-S1 on the left side and considering right-sided MBN block if pain worsened. The patient had a history of radiofrequency (RF) facet MBN in the past. On follow-up in December, noted that the patient had history of RF facet in the past; it got well however the pain recurred until it went with approval of the left facet RF with good results. She had right-sided pain and desired to proceed with right RF facet. recommended pre-certification for right facet RF L4-L5 and L5-S1 MBN. The patient was noted to have right-sided lumbar pain associated with severe spasms along with facet lumbar tenderness from L2-L3 through L5-S1 bilaterally. She had spasms noted from L1-L2 through L5-S1 bilaterally along with trigger points throughout the spine. She had pain worse on the right than left side to the thigh and leg. recommended a right L4-L5 through L5-S1 RF as soon as possible. The patient was to continue Darvocet trials.

2010: From January 12, 2010, through August 3, 2010, the patient had several follow-ups for complaints of lumbar pain, mostly on the right which was dull, ache, sharp, shooting and chronic in nature associated with severe spasms worse with rotation and extension of the lumbar spine and lumbar facet tenderness from L2-

L3 through L5-S1. She had bilateral trigger points noted throughout the spines and bilateral spasms noted from L1-L2 through L5-S1 bilaterally. The pain radiated to the thigh and leg on the right side. She had tingling/numbness mostly on the right side in the L4, L5 and S1 distribution. The patient was to continue medications including Zanaflex, Darvocet, and calcitonin nasal spray with the use of calcium supplementation with vitamin D. She was also to continue Mobic for joint pain.

In August, the patient was recommended a trial of Medrol Dosepak as soon as possible.

On December 29, 2010, the patient underwent AP spine bone density scan and left femur bone density scan.

2011 – 2012: On January 13, 2011, evaluated the patient for ongoing chronic lumbar axial pain, lumbar radiculopathy, facet lumbar spondylitic pain, chronic in nature. The patient had a history of lumbar facet right and left RF done one year ago with pain recurring. It was noted that the patient continued to have some pain despite physical and adjuvant therapies, tried and failed multiple medications in the past. She had exhausted all other oral medications, physical therapy and neuromodulation trial. discussed radiofrequency ablation pathophysiology with the patient and recommended right facet followed by right facet MBN RF.

On February 28, 2012, noted that the patient desired to proceed with invasive therapy as she had tried exercise plan, oral over-the-counter medication, ROM exercises and prescription medications with no benefits. She mostly had lumbar pain on the left which was chronic and was globally worsening. She had difficulty lifting and pushing associated with severe spasms worse with rotation and extension of the lumbar back. She had lumbar facet tenderness L2-L3 through L5-S1 bilaterally. She had spasms noted from L1-L2 to L5-S1 bilaterally and pain was in center of the lower back. She had associated symptoms including paresthesias. She had complaints worse on the left than right. She had tingling and numbness mostly on the left. The L4 and L5 distribution along with spasms/cramping of paralumbar, paragluteal, parasacral musculature and spasms localized at T12 to S3 paravertebral regions and significant spasms to serratus posterior muscle, longissimus thoracis muscle, spinalis lumbar muscle, piriformis muscle, gluteus medius/maximus and minimus muscles. She had significant spasms to multifidus lumbar musculature. She complained of pain mostly on the left. Diagnoses was lumbar and sacral osteoarthritis and thoracic or lumbosacral neuritis or radiculitis, unspecified. recommended ROM and strengthening, objective testing to evaluate clinical progression. Urine drug screen was also recommended. The patient was counseled and given information on diet, injury prevention, exercises, spinal cord stimulator information, R&B extensively discussed, SI joint exercises and ROM pamphlet was given. The patient was to follow-up in four weeks or p.r.n.

2013: On May 14, 2013, MRI of the lumbar spine without contrast showed the following findings: (1) There was extensive previous surgery with pedicular

screws seen at L1-L2 and bulging degenerative disc at T11-T12. The disc at T12-L1 was unremarkable. (2) At L1-L2, the disc was unremarkable. There had been previous laminectomy. There was no evidence of recurrent disc. (3) At L2-L3, there was significant facet joint arthropathy with a minimally bulging disc, but no evidence of significant spinal or foraminal stenosis. (4) At L4-L5, there was previous bony effusion with laminectomy. There was no evidence of significant spinal or foraminal stenosis. (5) At L5-S1, there was a bulging degenerative disc to the left of midline with minimal impingement upon the nerve rootlets.

On June 25, 2013, evaluated the patient for lumbar back pain, chronic lumbar axial pain, lumbar facet pain, lumbar radiculopathy, radiculopathy pain to lower extremity, chronic facet lumbar spondylitic pain, globally worse, right facet pain, right and hip pain. The patient was referred for minimally invasive injection therapy. Her pain level was 7/10. She had exhausted all other treatments and adjuvant therapies and desired to proceed with invasive therapy and her exacerbated pain to spine was doing better. She had radiculopathic pain extending laterally and radicular pain recurred. She desired intervention as the facet spondylitic pain was worse. She also desired to continue injection series, each injection had global accumulative benefits and procedure helped to decrease pain without side effects. Examination of the lumbar spine showed tenderness from L2-L3 through L5-S1 bilaterally, facet tenderness, decreased ROM, spasticity/dystonia positive, flat lordosis, Ashworth score +3/4 ; spastic para-thoracic, para-lumbar, para-gluteal musculature; spastic knots to the spine; well-healed scar midline, lower levels tenderness; trigger points throughout spine, provocation positive taut muscles bundles and SI joint tenderness. She had Faber's positive bilaterally, gluteal spasms, positive piriformis muscle spasticity, coccyx tenderness, tenderness of the facet joint, rib tenderness, T10, T11, T12, spasticity to musculature in the thoracic spine, rhomboid, multifidus and para-thoracic musculature. She had positive tenderness in the fascia lata. Diagnoses were radicular syndrome of lower limbs, lumbar and sacral spondyloarthritis and postlaminectomy syndrome of the lumbar region. opined that the patient had tried and failed multiple medications in past. The procedures have helped to decrease pain without SA; however, she continued to have some pain. recommended urine drug screen and precertification for a left L4-L5 selective nerve root block (SNRB), facet block right and left L3-L4 to L5-S1 no RF and right facet MBN block L4-L5 through L5-S1.

Following history is noted: *A computerized tomography (CT) of the lumbar spine dated December 18, 1985, showed right-sided herniated nucleus pulposus (HNP) at L4-L5; CT of the lumbar spine dated August 30, 2007 showed L2-L3 instability with secondary spinal stenosis, L4-L5-S1 fusion, SI joint osteoarthritis (OA); MRI of the hip dated January 23, 2008, showed mild hip noted, minimal effusion minimal GTTB; MRI of the lumbar spine dated March 19, 2009, showed L1-L2 moderate degenerative disc disease (DDD) bilateral disc bulge severe left NFN, L2-L3 moderate DDD bilateral facet disease moderate disc bulge, L3-L4 severe bilateral facet disease, L4-L5 severe bilateral facet disease laminectomy, L5-S1 mod DDD BB disc bulge severe bilateral facet disease. EMG (lower) dated July 2009 showed chronic bilateral L4 radiculopathy, mild bilaterally peroneal*

mononeuropathy bilateral, etiology unknown. A bone scan dated August 4, 2009, showed hypertrophic changes of the lumbar spine, bone density left femur consistent with early osteopenia.

Per utilization review dated July 2, 2013, the request for right facet block L4-L5 through L5-S1 was denied, with the following rationale: *“The patient is a female whose date of injury is xx/xx/xx. Per required medical evaluation (RME) dated May 19, 2010, the patient was lifting a box overhead when she felt something rupture in her back. She underwent L4-L5 discectomy in xxxx followed by fusion L4-L5 and S1 in 1992. The patient subsequently underwent L1 through L3 fusion with instrumentation in 2008 and 2009. The RME doctor opined that active interventional treatment is no longer indicated in the absence of radiculopathy. There is a gap in treatment records until follow up note dated June 25, 2013. On physical examination, there is tenderness to bilateral L2-L3 through L5-S1. Faber’s is positive bilaterally. Based on the clinical information provided, the request for right facet block L4-5, L5-S1 is not recommended as medically necessary. There is no comprehensive assessment of treatment completed to date or the patient’s response thereto submitted for review. The patient presents with a diagnosis of radicular syndrome of the lower limbs. Current evidence-based guidelines note that facet blocks are limited to patients with low back pain that is non-radicular. Additionally, the patient is status post L4-L5 and S1 fusion. ODG notes that facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. Peer to peer discussion was unsuccessful.”*

Per reconsideration review dated July 10, 2013, the request for right facet block L4-L5 through L5-S1 was denied, with the following rationale: *“I discussed the request on July 9, 2013. The patient has a fusion at L4-S1. This is a contradiction to any facet procedure at these levels as per ODG criteria. The also suggested a Selective Nerve Block at the same time as he asked for medial branch blocks but since the SNB is done to treat radiculopathy this is another contraindication to doing facet procedures.”*

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

According to the ODG, criteria for use of therapeutic intra-articular and medial branch blocks, are as follows:

1. No more than one therapeutic intra-articular block is recommended
2. There should be no evidence of radicular pain, spinal stenosis, or **previous fusion**
3. If successful(initial pain relief of 70%, plus pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy(if the medial branch block is positive).
4. No more than 2 joint levels may be blocked at any one time.
5. There should be evidence of a formal plan of additional evidence-based activity and exercise in addition to facet joint injection therapy.

Furthermore, according to the ODG, 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 be approximately 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.”

The patient has had a fusion at the L45 and L5S1 levels, thus does not meet the ODG criteria for a diagnostic or therapeutic facet block/injection.

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

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES