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Notice of Independent Review Decision

DATE: January 28, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Bilateral L3-S1 Medial Branch Block

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

The reviewer is certified by the American Board of Anesthesiology with secondary practice in Pain Management with 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 medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

12/08/11, 12, 12/11, 12/19/11, 12/26/11: Visit
12/08/11: Left Shoulder, Two Views report interpreted
12/08/11: Lumbar Spine, Three Views report interpreted
12/29/11: MRI of the Lumbar Spine without Contrast report
01/11/12, 01/25/12, 02/20/12, 03/22/12, 04/12/12, 05/14/12, 05/21/12: Visit
01/18/12: MRI of the Left Shoulder without Contrast report
01/27/12: Physical Therapy Evaluation
01/27/12, 02/10/12, 02/13/12, 02/17/12, 02/22/12, 02/24/12, 03/02/12, 03/05/12,
03/07/12, 03/19/12, 03/21/12, 03/23/12: Progress Note
06/07/12, 07/20/12, 08/27/12, 10/04/12: Visit
07/19/12: MRI Left Shoulder without Contrast report
11/05/12, 11/26/12: Evaluation
11/12/12: Evaluation
11/26/12: Letter of Request for procedure
11/26/12: UR performed
12/31/12: UR performed

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who injured his left shoulder and lower back when he fell at work on xx/xx/xx.

12/08/11: The claimant was evaluated for an injury. He complained of neck, shoulder, and lumbar pain. Current medications included Lovaza, Mobic, and simvastatin. On examination, tenderness to palpation of the neck, lumbar spine, and left shoulder. He was given a prescription for Motrin. He was taken off work until 12/12/11.

12/08/11: Lumbar Spine, Three Views, report. IMPRESSION: Degenerative changes as described above. There is no evidence of fracture.

12/29/11: MRI of the Lumbar Spine without Contrast report. IMPRESSION: Mild anterolisthesis L5 in respect to S1. Changes at multiple disc levels as described above. Bilateral laminectomy at L5. Degenerative changes in the disc L4-L5 and L5-S1.

01/27/12: The claimant was evaluated for lower back and left shoulder pain after injuring himself at work. He stated that his pain was exacerbated by bending, twisting, and overhead activities. He stated that the pain was relieved with pain medications. He rated his pain as 6/10. Strength testing was 4 to 4-/5. Straight leg raised positive bilaterally for low back pain. Sensation was intact. Lumbar paraspinals were tender to palpation. DTRs were 2+ at the knees and ankles bilaterally. ASSESSMENT: Exhibits decreased ROM in lumbar spine, muscle weakness/guarding, and pain with movement. Symptoms are consistent with mechanism of injury. Pt has good rehab potential. PLAN: Initiate manual therapy, strengthening, IFC/NMREED, and pain modalities 3 times per week x 4 weeks or until goals met.

01/27/12 through 03/23/12: The claimant participated in 12 sessions of physical therapy. On March 23, 2012, he reported a pain level of 8/10 to the low back. It was noted that he tolerated treatment well.

03/22/12: The claimant was evaluated. It was noted that he was recently dismissed from his job for "no show." He was tolerating all medications well and was requesting refill. His current medications included simvastatin, Motrin, Mobic, Vicodin, Soma, and Lovaza. On physical exam, he had tenderness to the lumbar spine on palpation with moderately reduced lumbar spine range of motion. He was given refill prescriptions.

05/21/12: The claimant was evaluated for worsened low back pain. It was noted that he was requesting a refill on Vicodin as he was out of this medication for eight days. He admitted to taking his friend's Oxycodone. He reported that he was not working due to his injuries. On physical exam, the lumbar spine was tender with moderately reduced range of motion. DTRs were preserved and symmetric. PLAN: DUA – patient refused, states unable to urinate. Patient left. Longer-term

Controlled Substance Therapy for Clinic Pain Agreement signed and explained to patient. Referral for further narcotic pain management.

06/07/12: The claimant was evaluated. He stated that his symptoms were unchanged. He stated that no referral to pain management was given. He stated that he had not had any hydrocodone in over one month. ASSESSMENT/PLAN: Long term use meds, THC positive (to be sent for conformation), referral to ortho.

07/20/12: The claimant was evaluated. He stated that his symptoms were unchanged. It was noted that he was seen and was given cortisone injection. It was noted that previous UDS was positive but conformation was negative.

10/04/12: The claimant was evaluated. He stated that his symptoms had improved. On examination, he had tenderness in the lumbar spine with moderate pain with motion. PLAN: ordered more PT. Followup after DD.

11/05/12: The claimant was evaluated for back pain and left shoulder pain. It was noted that he was followed for lumbar sprain with posttraumatic aggravation of preexisting grade 1 spondylolisthesis at L5-S1 with previous back surgery. On physical exam, the lumbar spine revealed minimal range of motion with tenderness throughout. He was given a left shoulder steroid injection. He was referred for evaluation and epidural injection for his back.

11/12/12: The claimant was evaluated for low back pain. He rated his pain as 5 to 9/10 when walking. He noted significant periods of relief when taking hydrocodone. He stated that his pain would get worse when walking and standing in spite of lying down and massage therapy. He had poor sleep. It was noted that physical therapy and TENS unit did not help and made it worse. It was noted that he had an operation on the lower back disc 6-7 years prior. His current medications were listed as Lortab, Flexeril, and Biofreeze. On physical exam, he was noted to be moderately obese. Sensation was intact. Strength was +5 in the left lower extremity and +4 to 5 in the right lower extremity at the knee and ankle but decreased possibly due to pain. DTRs were +2 bilaterally at the knees and ankles. His gait was slightly antalgic. He had tenderness to palpation over the lower back area and sacroiliac joint on the left. He had no clubbing, cyanosis, or edema of the extremities. No atrophy was noted. Review of MRI showed L4-L5 moderate disc bulging with bilateral neural foraminal narrowing, moderate-severe spinal stenosis, bilateral facet joint disease, L5-S1 mild bulging of the disc without spinal stenosis, severe facet joint disease bilaterally, and bilateral laminectomy L5, mild anterolisthesis L5-S1, and degenerative changes in the discs L4-L5 and L5-S1. DIAGNOSES: Lumbar spondylosis without myelopathy, lumbar radiculitis, possible lumbar radiculopathy, chronic low back pain, postsurgery syndrome, and degenerative disc disease. PLAN: The patient is a 50-year-old male referred for epidural steroid injection, and we will proceed with an L4-L5 and L5-S1 epidural steroid injection after we do the L2 to L5. We will do L3 to S1 medial branch block bilaterally first and then we will proceed with the transforaminal. If the medial branches do not alleviate the pain, we will schedule for lumbar transforaminal

epidural steroid for lumbar radiculitis with possible radiculopathy. There are two problems going on with this patient at the present time.

11/26/12: The claimant was evaluated for left shoulder and back pain. On physical exam, lumbar spine demonstrated restricted forward flexion. Review of the report indicated that he was placed at MMI on 10/30/12 with 10% impairment. He was diagnosed with a cervical and lumbar sprain, left shoulder sprain, and head injury. He was assigned 5% impairment for his back, 0 for his neck, 5% for the left shoulder based on range of motion, and 0% on his head.

11/26/12: Letter. "Upon reviewing the patient's chart, the patient had fallen and has primarily back pain, for which we wanted to proceed with medial branch blocks bilaterally in the lumbar region for this patient. I believe that this would be the most efficacious way of treating the patient's back pain at this time. The patient does have two problems. He has significant neuroforaminal stenosis in the lumbar region and would possibly benefit from epidural steroid injections in the future. But seeing as his back pain is his predominant type of pain, we believe that proceeding with the medial branch blocks at this time would be beneficial in diagnosis and possible proceeding to radiofrequency ablation of these nerves in order to relieve his back pain. Either course of action is appropriate in this situation that epidural steroid be administered or medial branch block be done in hopes that we could ablate those nerves in the future. We request that this would be approved for this condition if it would be preferable for risks and complication to start with the epidural steroid injection to see if we get more relief with that. We will be happy to do that in this clinic."

11/26/12: UR performed. REVIEWER COMMENTS: As per latest medical report dated 11/12/12, the patient presented with chronic low back pain. The physical examination showed grossly intact sensation in the lower extremities, weakness (+4 to 5) in the right lower extremity possibly due to pain, normoactive deep tendon reflexes, slightly antalgic gait, and tenderness over the low back area and sacroiliac joint on the left. Facet tenderness over the contemplated injection sites, to suggest facet joint pathology was, however, not documented. Furthermore, the number of targeted levels is deemed in excess of guideline recommendations. There was also no documentation of a contemplated neurotomy if the requested injections are successful. Finally, the patient is noted to be obese with a BMI of 40.74 as per 10/04/12 report. There was none in the records that addressed this issue which is an important factor in the continued back symptoms of the patient. The patient is noted to have attended prior PT sessions that were deemed of no benefit; however, given the current clinical data, the medical necessity of a bilateral L3-S1 medial branch block is not established at this point.

12/31/12: UR performed. REVIEWER COMMENTS: Updated documentation submitted for this appeal includes the 11/26/12 appeal letter which specified a possible plan to eventually proceed to radiofrequency ablation following the Medial Branch Blocks. However, the other concerns cited in the previous review were still not addressed. Paravertebral tenderness was still not documented in the latest physical examination to clinically support the diagnosis of facet joint

pathology. Likewise, the number of requested injection levels is still in excess of the recommended two levels specified in the referenced guidelines. A concurrent plan to address the patient's significant obesity (a potential contributing factor to his present condition) was also still not documented. Based on these grounds, the medical necessity of this request is not substantiated, and the previous non-certification is upheld.

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

The previous adverse decisions are upheld. The reasons cited by the previous UR physicians are correct. describes multiple degenerative changes and requests extensive Medial Branch Blocks followed by radiofrequency ablation. As the previous UR physicians state, the ODG specifically recommends only two injection levels for precise treatment. There is insufficient documentation that facet joint pathology is the etiology of the symptoms. The claimant has multiple degenerative changes in his lower back and has had no significant relief from physical therapy, including no documentation of participation in a home exercise program. Prior to the consideration of an invasive procedure, the institution of a progressive home exercise regimen should be begun. This should be coupled with significant dietary restrictions to address his obesity and elevated BMI of 40+ as per the October 4, 2012 report. Only after he has demonstrated the ability to personally address the lower back pain symptoms and his physical state and started corrective action should selective, precise invasive procedures be considered. There is no documentation that this has been considered. Therefore, the request for Bilateral L3-S1 Medial Branch Block is not medically necessary and is non-certified.

ODG:

Facet joint diagnostic blocks (injections)	<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)</p> <p><i>Etiology of false positive blocks:</i> 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)</p> <p><i>MBB procedure:</i> 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</p>
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	<p>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) (Pneumatics, 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.</p> <p>Criteria for the use of diagnostic blocks for facet “mediated” pain: Clinical presentation should be consistent with facet joint pain, signs & symptoms.</p> <ol style="list-style-type: none"> 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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Facet joint medial branch blocks (therapeutic injections)	Not recommended except as a diagnostic tool. Minimal evidence for treatment. <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
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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 *Pain Physician*.] The average relief per procedure was 11.9 ± 3.7 weeks.

Pain Physician 2007: 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).

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)**